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ABSTRACT

In 1996, the federal Office of Rural Health Policy awarded 3-year outreach demonstration grants to 25 projects to provide direct primary and preventive health care services to rural residents in 20 states. The grant program allows recipients to test innovative ideas against the challenges of rural health care delivery, such as provider shortages, geographic isolation, and uninsured or underinsured children and families. Recipients must form a consortium of three or more local and state agencies or institutions to work together toward project goals. All the projects in this funding cycle succeeded in their efforts, but the populations served and the models implemented were extremely diverse. Fourteen projects focused on the specific needs of infants, children, or adolescents. Among other populations, women were served specifically by 11 projects, minority groups (Hispanics, African Americans, Native Americans, or Amish) by 8 projects, and the elderly by 6 projects. Six projects focused their activities in rural schools. Eleven projects provided continuing education opportunities to health professionals. Health education, health promotion, or disease prevention were the focus of 11 projects, with topics such as substance abuse, smoking prevention, mental health, nutrition, and first aid. Descriptions of the 25 projects include population served, services provided, innovative features, results, potential for replication, plans for continued funding, and contact information. (Contains title and subject indexes, a glossary, and a project locator map.) (SV)

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U.S. Department of Health & Human Services

HRSA

Health Resources and Services Administration

OFFICE OF RURAL HEALTH POLICY

THE OUTREACH SOURCEBOOK

Volume 6

RURAL HEALTH DEMONSTRATION PROJECTS

1996 to 1999

U.S. DEPARTMENT OF EDUCATION
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PREFACE

The Federal Office of Rural Health Policy (ORHP), Health Resources and Services Administration, is proud to present *The Outreach Sourcebook—Volume 6: Rural Health Demonstration Projects, 1996-1999.*

Since 1991 ORHP has emerged as a national leader in supporting the development and testing of innovative health care delivery models that hold tremendous promise for rural communities across the Nation. *The Outreach Sourcebook* continues this tradition by summarizing the experiences of the 25 grantees funded in September 1996. The stories included in this volume underscore the compelling and challenging health care needs that still exist in rural America. As you will see, these programs are as diverse in their scope as the populations they served.

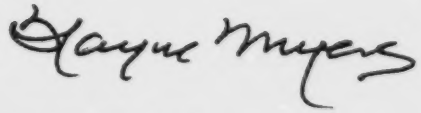
This volume highlights the projects' successes as well as their shortcomings. It also describes the innovative health care access and delivery solutions they tested and how other rural communities can benefit from their experience. Most important, it sheds new light on the enormous value of collaboration—not only for the organizations that work together to achieve mutually important goals but also for the people such organizations are charged to serve and for the community as a whole.

The individual program descriptions that follow are based on project reports developed by the grantees. I believe that *The Outreach Sourcebook* can serve as a valuable resource for every rural community in every State. For rural leaders and future grant applicants, these anecdotes may serve as catalysts for new approaches to rural health care delivery. For health policymakers, these stories are a reminder that our job in rural America is far from over and that rural communities need our ongoing support.

For more information about the Rural Health Outreach Demonstration Grant Program, please call the office at (301) 443-0835 or visit our Web site at *www.nal.usda.gov/orhp*. If you would like more information about the projects described in this volume, please feel free to contact the projects directly. Each project description includes contact information for your convenience.

I hope that you will enjoy reading these stories as much as we enjoyed preparing this volume.

Sincerely,



Wayne Myers, M.D.
Director
Office of Rural Health Policy
Health Resources and Services Administration

In 1996 the Office of Rural Health Policy (ORHP), Health Resources and Services Administration, awarded Rural Health Outreach Grants to 25 projects located in 20 States. These projects, scattered from Vermont to Louisiana to Alaska, were designed to test and demonstrate innovative models for the delivery of primary medical care, prevention services, and health professions training as well as other health care delivery efforts. Each project funded in 1996 was required to develop a consortium of local and State agencies and organizations so that the fullest range of health care resources could be brought to the communities in which the programs were established.

Together, these projects addressed a broad range of health care delivery challenges. Some of these challenges, such as geographic isolation from services and a shortage of rural health care providers, have existed in rural communities for many years. Others, such as enrolling uninsured and underinsured children and families in State Children's Health Insurance Programs or Medicaid, have emerged in recent years as a result of dramatic and unprecedented changes in the way health care services are organized, financed, and delivered. In all cases, however, each of these projects was able to fashion creative and workable solutions to the unique health care needs of its community. More important, these consortia succeeded in their efforts to increase access to health care, reduce or eliminate barriers to care, and improve the lives of thousands of rural Americans.

All the consortia created as a result of ORHP's 1996 Rural Health Outreach Grant cycle succeeded in their efforts. However, as the following descriptions show, the key ingredients to their success often varied from one project to another. Several projects cited flexibility in meeting the changing needs of the target population as the key to their success. Others pointed to different reasons for their collective accomplishments, such as frequent and open communication among the consortium partners, a true spirit of cooperation and collaboration, or the vigorous leadership of a single individual or organization. For whatever reasons, thousands of rural residents whose health care needs had largely gone unmet are healthier, happier, and more productive today than they were prior to 1996. And their prospects for good health in the years to come are significantly brighter.

The diversity of the following programs—both in terms of the populations served and in the models implemented—cannot be overstated.

- The Healthy Connections program in Truro, Massachusetts, focused its efforts on enrolling area children in the State-sponsored Children's Health Insurance Program.
- The Vermont Coalition of Clinics for the Uninsured in Middlebury opened nine free clinics across the State. Between 17.5 and 22.0 percent of uninsured adults in the entire State received services at one of the clinics at least once during the grant cycle.
- The Sunshine Community Health Center in the Upper Susitna Valley of Alaska and Project SCOUT in Albany, Texas, created one-stop-shopping health care programs for local residents.
- To reduce morbidity and mortality rates associated with chronic diseases, the Clinton County Community Health Outreach Project in Lock Haven, Pennsylvania, offered health screenings and health education at local fire stations. A concerted effort was made to reach local Amish residents, which ultimately resulted in the installation of hitching posts for horses at the Sugar Valley firehouse.
- The On Different Ground program in Rhinelander, Wisconsin, provided comprehensive, in-home mental health and substance abuse services for elderly and disabled individuals, while a project in Miami,

Oklahoma, provided in-home custodial and personal care for infirm elderly persons. A program in Sheridan, Wyoming, used its grant to better coordinate existing rehabilitation services for elderly and disabled residents.

- A school-based program in Washington, Iowa, not only provided mental health and substance abuse services to young people but also succeeded in helping Spanish-speaking parents understand what they can do to help their children. Similarly, another program in Lenoir City, Tennessee, succeeded in getting 70 percent of area students enrolled in a school-based health center.
- Campbell County Memorial Hospital in Gillette, Wyoming, used grant funds to expand its emergency medical services so that emergency care would be available around the clock.
- A program in Turtle Lake, Wisconsin, created a mobile dental clinic that provided oral health services at county health departments, a community hospital, Head Start centers, supervised care facilities, and a church fellowship hall.
- The Governor's Commission on Women in Vermont launched a public education initiative to educate women about managed health care and the most effective ways to use it.
- A project in Artesia, New Mexico, offered diabetes education and management services to individuals with diabetes. Approximately 75 percent of those served by the project were Hispanics.
- Instead of hiring full-time health care providers to provide a range of primary medical services, the Ashland Community Health Center in Montana joined forces with health care providers from four medical centers in surrounding communities to provide care on a rotating schedule. About 35 percent of those served by the program were Native Americans.
- The B-H-K Child Development Board in Houghton, Michigan, contacted parents of newborns at local hospitals to enroll their infants in a childhood immunization registry. As of July 1999, 90 percent of children ages 19 to 35 months listed in the database were fully immunized compared with 62 percent of children the same age who were listed in the health department's database. Another immunization program in Poplar Bluff, Missouri, succeeded in increasing childhood immunization rates to nearly 100 percent in a five-county area.
- The Dakota Health Network in Aberdeen, South Dakota, launched a telehealth and telemedicine program to bring primary health care, specialty medical consultations, and health education programs to 12 rural counties. The program also enabled local health care providers to receive continuing education credits without leaving their homes or patients.
- The Saludando Salud initiative in Mankato, Minnesota, created a weekly Spanish-language radio show that communicated health promotion and disease prevention messages to local Latinos.
- A program in south Texas employed nine *promotoras* who served as health educators for Spanish-speaking residents and who provided referrals to primary care.
- The Rural Primary Care Support Network in Hendersonville, North Carolina, launched a 1-year fellowship training program designed to prepare physicians for practice in rural areas. The program also sponsored the Western North Carolina Practice Opportunity Fair, which matched health care providers looking for jobs with practices and communities throughout the region that had openings.

These are just a few of the innovative health care delivery and training approaches that were implemented as a result of the 1996 Rural Health Outreach Grants. The good news is that the vast majority of these programs continue to fill a crucial and compelling need in their communities.

These models hold tremendous promise for the delivery of health care in rural areas. In fact, every rural community in every State can benefit from the experiences of these projects and gain new insight on how to address the unique needs of their population.

Each project description contained in this volume includes the name of an individual who was intimately involved with the implementation of the project. The reader is encouraged to contact the identified individual for more detailed information about the project.

Glossary of Frequently Used Terms

AHA	American Heart Association
AIDS	Acquired Immunodeficiency Syndrome
CME	Continuing Medical Education
CPR	Cardiopulmonary Resuscitation
ECT	Emergency Care Technician
EKG	Electrocardiogram
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EPSDT	Early Periodic Screening and Diagnostic Treatment
HIV	Human Immunodeficiency Virus
IHS	Indian Health Service
MCH	Maternal and Child Health
STD	Sexually Transmitted Disease
WIC	Women, Infants, and Children

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Houghton
Mankato
Rhinelander
Ashland
Aberdeen
Sheridan
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Monroe
Lock Haven
Montpelier
Windsor
Middlebury
Truro
Potosi
Evarts
Poplar Bluff
Lenoir City
Hendersonville
Miami
Helena
Albany
Ferriday
Pacific Ocean
Atlantic Ocean
Gulf of Mexico
AK
Talkeetna
HI

Population Served

The Sunshine Community Health Center (SCHC) is nestled in Alaska's Upper Susitna Valley, a frontier rural area encompassing 12,250 square miles—a land mass larger than the States of Maryland and Delaware combined. The region has seen its population double to approximately 5,000 people in the past 10 years, and although many people in the valley live close to small roads, many others can travel only by snowmobile, boat, or dogsled or on foot.

Area residents are predominantly white and impoverished, and prior to receipt of a Rural Health Outreach Grant, the area's social service infrastructure was nearly nonexistent, making access to basic health care a formidable challenge. Over the years, urban-based health service agencies, such as those located in Wasilla, Palmer, and Anchorage, had done little to expand their reach into this medically underserved region of Alaska, and the population's basic health care needs went largely unmet.

As a result, SCHC staff members realized that there was only one way to meet the community's health care needs—by developing appropriate programs themselves.

Services Provided

Using funds provided by its Rural Health Outreach Grant, SCHC staff members began to establish formal relationships with urban-based service agencies in Wasilla, Palmer, and Anchorage so that they could begin to address at least some of the population's most significant health problems. Before long, SCHC had built a health care consortium that included the Mat-Su Council (now called the Mat-Su Recovery Center), the Valley Women's Resource Center, and Healthy Families Mat-Su—all of which are located in the Wasilla/Palmer area. *For the very first time*, a range of health care and related services became available to Upper Susitna Valley residents, including substance abuse treatment and community education programs, advocacy for families experiencing domestic violence, and a Healthy Families Mat-Su program that enabled service providers to go directly to the homes of families with new infants. SCHC was also able to hire a mental health clinician to operate a new mental health services program. All residents in the region were offered these services, regardless of their ability to pay.

ALASKA

SUNSHINE COMMUNITY HEALTH CENTER

TALKEETNA, ALASKA

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SCHC and the service consortium enjoyed exponential growth. SCHC hired a second physician's assistant to cope with the growing demand for primary medical care, as well as a psychiatric nurse practitioner, who was nearly overwhelmed by the immediate demand for her services. The Mat-Su Recovery Center and Healthy Families Mat-Su programs hired staff to work on-site at SCHC. The Valley Women's Resource Center placed a full-time family advocate at SCHC to work with individuals and families in crisis and to coordinate the development of "Safelight," a local grassroots organization working to establish a safehouse system for victims of domestic violence. SCHC also hired a clinic manager to oversee the program's expansion and to manage the increased demand for services.

Innovative Solutions to Problems

As is often the case, SCHC's exciting growth came at a price. Rural life is not only difficult for the client; it is also an enormous challenge for service providers. Meeting the complex and wide-ranging needs of rural communities is both professionally and personally demanding. The challenge for service providers is magnified by the importance of maintaining confidentiality and the difficulty of working independently. When staff members work at one organization but are paid by another, it can easily create supervision and communication problems. For SCHC, these challenges nearly resulted in the collapse of the consortium. However, a series of meetings between the consortium partners led to a renewed commitment among the organizations involved, willingness to reexamine existing programs, and desire to implement needed changes.

This renewed commitment did not prevent new challenges from arising. For example, when SCHC was forced to dismiss its psychiatric nurse practitioner, it was unable to recruit an ideal, totally reimbursable mental health care provider. Because of the high demand for mental health services, the consortium was expanded to include Life Quest, a community mental health center, which provides a mental health professional at the Sunshine clinic 6 days per month.

Results

In spite of the "hiccups" caused by staff turnover and the challenges associated with the consortium's growth, the Rural Health Outreach Grant enabled SCHC to bring a broad range of health care options to Alaska's Upper Susitna Valley region. The ultimate measurement of this project's success is that the original consortium not only remained intact but has been expanded. The full range of services planned for this project continue to be offered.

One of the most exciting results of the Rural Health Outreach Grant project is that, for the first time, most of the critical needs of community members can be met within their own community. At SCHC, mental health, substance abuse treatment, and primary health care services are delivered under one roof, enabling service providers to work as a team to address client needs from a comprehensive, holistic approach to care. In an isolated rural area, this level of multidisciplinary interaction is unique, and that all these services are used—and used often by many different clients—underscores the project's success.

> "WE LEARNED THAT PERSONNEL SELECTION IS THE MOST CRITICAL ASPECT OF IMPLEMENTING AMBITIOUS PROJECTS AND THAT HAVING THE RIGHT PEOPLE FOR THE JOB IS AT LEAST AS CRITICAL AS THEIR TECHNICAL SKILLS. WE HAVE LEARNED TO LOOK NOT EXCLUSIVELY AT PEOPLE'S QUALIFICATIONS BUT AT HOW WELL THEY WORK IN A TEAM SETTING, HOW OPEN AND FLEXIBLE THEY ARE, AND HOW WILLING THEY ARE TO LEARN FROM THEIR MISTAKES. WE HAVE ALSO LEARNED THAT [ALTHOUGH] PROGRAM DEVELOPMENT CAN BE AN ARDUOUS PROCESS, LAUGHING A LOT HELPS TO KEEP THINGS SANE."
>
> JESSICA STEVENS
> SCHC MEDICAL DIRECTOR

Community education has been a significant key to the project's success. SCHC not only informs and educates residents about new and expanded services in the community but also promotes the concepts of community health and wellness. A traveling puppet show, BABES, is being used in schools and at community events to educate youth and adults about the effects of alcohol and drug use. A biweekly community radio program hosted by clinic personnel provides a forum in which to discuss health issues relevant to the community. A Child Abuse Task Force has been created, and SCHC is actively involved in the borough's Sexual Assault Response Team.

SCHC is now widely recognized throughout the borough and the State as an innovative, holistic health care provider. The consortium has become a model of cooperation that has managed change in an imaginative and positive way, and each consortium member is committed to continuing with this project.

Potential for Replication

SCHC staff and consortium members identified several ingredients that were key to the program's success:

- Ensure a strong vision based on shared goals, mutual understanding, and community needs.
- Build strong support networks. Areas of potential conflict need to be identified and addressed early in the program's development.
- Clearly articulate supervisory relationships. For example, joint supervisory agreements should be written and agreed on by all involved organizations, and interagency chains of command should be clearly described.
- Try to have more than one person from a coalition agency at the host organization. If this is not possible because of financial or time constraints, make sure the relationship between the organizations involved is highly

interactive and reciprocal. Key personnel should have time available to work at both agencies on a regular basis.

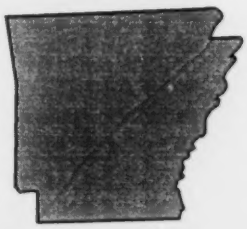
- Hire people who are good team players and are flexible.
- Be patient.

After the Grant

This program was intentionally set up so that Federal grant dollars would diminish in each year of the grant, forcing consortium members to work together to sustain the project. Today, each consortium member has fully absorbed the financial burden of the programs started as a result of this grant. Healthy Families Mat-Su, the Mat-Su Recovery Center, and the Valley Women's Resource Center are all funding their staff positions through other financial sources. Life Quest will continue to support the delivery of mental health care until more secure and expanded funding is in place. The program is also developing a similar coalition of tertiary care organizations to significantly expand access to primary care services throughout the region. When funded, this new network, called Susitna Rural Health Services, will take the clinic in new directions.

In addition, the Sunshine clinic has achieved New Start status as a Section 330 Community Health Center, which will allow the clinic to provide ongoing operational support for its programs as well as add other services, such as dental care, case management, full-time mental health services, a Head Start program, a teen center, and it is hoped an HIV outreach/prevention program.

ARKANSAS



MARVELL MEDICAL CLINIC

HELENA, ARKANSAS

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Population Served

Before the opening of the Marvell Medical Clinic, the citizens of Marvell, Arkansas, had four choices with respect to obtaining health care. First, they could visit a community health center located more than 25 miles away. Second, they could visit the Helena Regional Medical Center and wait up to 5 hours for care because the physicians are overworked. Third, they could travel an even greater distance to an urban health care facility. Or fourth, they could forgo care entirely—the most typical scenario.

Transportation to a health care site was particularly a problem for Marvell residents, who are 80 miles from the closest urban health care facility. No public transportation existed in the area, so residents without transportation would often pay a friend or relative as much as $50 for the trip. Dental services were also nonexistent, and there was no opportunity for any type of health education for residents or continuing education for health care professionals.

The small, rural community of Marvell is located in Phillips County—in the heart of the Arkansas Delta region. Marvell has a population of approximately 1,500, with about 4,500 people living in the target service area. In Marvell, 58 percent of the population consists of racial and ethnic minorities. Only 43 percent of all adults have completed high school, 46 percent of the population lives at or below the poverty level, and 24 percent is age 65 and older. Critically high rates of mortality; job-related injuries; and a prevalence of serious, untreated, and chronic health conditions are common. The area's infant mortality rate is 12 percent, and the teen pregnancy rate is 17 percent. In fact, a recent Harvard study reported the Phillips County ranks among the Nation's 10 worst in life expectancies for both men and women.

Services Provided

The grant provided funding for a broad range of services, including:

- A handicapped-equipped van and a cardiopulmonary resuscitation (CPR)-certified driver
- Patient education classes, including CPR, first aid, nutrition, drug interactions, breast cancer, and hypertension and a weekly senior citizens group called "Classics"

- High school student education classes on substance abuse and on dissection of the heart
- Medical consultations and continuing education courses for local health professionals by interactive, two-way video
- Daily dental services
- Diabetes and Alzheimer's disease support groups
- Funds to hire a project coordinator.

A consortium of three local entities—the Helena Regional Medical Center (HRMC), Delta Health Education Center (DHEC), and Mid-Delta Community Health Center (MD/CHC)—created the Marvell Medical Clinic. HRMC purchased, installed, and maintained medical and office equipment; hired primary care providers and administrative support staff; and provided overall clinic management. DHEC coordinated and implemented the project, operated a compressed video system, coordinated health professions' student rotations, managed patient education classes, and publicized the clinic's programs and services. MD/CHC provided a dentist and directed the purchase and installation of dental equipment at the clinic. The city of Marvell also played an important role by providing the building for the clinic, which was paid for by contributions from local citizens, and by offering office space with free rent and utilities.

Innovative Solutions to Problems

A van, purchased through the grant, ensured that the people of Marvell and the surrounding areas had transportation to and from primary care services at the clinic and specialty services in Helena and Little Rock. This free service was limited to clinic patients. The van was also used by the Marvell Dental Clinic to increase access to dental care and enabled Marvell School District students to have access to complete dental care. The van picked up students at school, transported them to the dental clinic, and took them back—all within a few hours.

The project coordinator managed health education activities. A bimonthly health education newsletter was written and mailed to nearly 1,900 households in Marvell and the surrounding areas. The newsletter contained information about the Marvell Medical Clinic, upcoming events at the clinic and in the city of Marvell, health education stories, and healthful recipes. Flyers were also sent to the nursing home, the pharmacy, churches, area businesses, day-care facilities, and schools to advertise the clinic's programs.

One of the program's unique features was the use of compressed video to provide community health education programs and professional training opportunities for area providers, including nurse practitioners, nurses, pharmacists, dentists, and clinical staff. The Diabetes Support Group and the Alzheimer's Support Group were offered every other month via the interactive

video system. Between September 1998 and September 1999, 75 medical consults were provided via video. Consults were arranged through the University of Arkansas for Medical Sciences, and virtually any specialty field could be used, including dermatology, diabetes nutrition and education, weight management, adult and child psychology, pain management, and pharmacy. Many of the patients who used the system indicated that they probably would never have had access to the medical expertise of a specialist had it not been for the interactive video system. The system saved money and eliminated more than 6 hours of travel, waiting, and office visit time by clients.

One of the biggest challenges encountered by the program involved getting people interested in obtaining free health education, scheduling these programs at convenient times, and transporting the people. Solutions to these problems included encouraging participants to help promote programs, sending personal invitations, and scheduling programs on different days and at different times.

Results

Since its inception in 1993, the Marvell Medical Clinic has created more than 2,250 patient charts and had more than 11,400 patient contacts.

The van provided 1,617 free rides to those who may not have otherwise received medical or dental services. More than 30 in-home health education presentations were given, at which more than 500 people received some type of health education. Examples of these programs included health fairs, nutrition and cholesterol classes, and a smoking cessation class. The "Rite Bite," a diabetic cooking school, was held in cooperation with the local Cooperative Extension Service in two locations. Parents of children in day care received information on children's health issues. Foster grandparents learned about first aid, safety, and health-related problems among the young and old. Bus drivers received refresher courses in basic first aid, and babysitter training classes and Health Smart summer programs were held for youth. A local urologist offered free prostate screenings, and nearly 100 men took advantage of this service, of whom 10 percent were referred for further testing.

In addition, two mobile screenings were held in rural communities—one for blood sugar and cholesterol testing and one for flu vaccinations. More than 20 interactive video programs were offered at the clinic to nearly 200 participants, and 44 programs were held for local health care professionals, who received 127 continuing medical education hours or continuing education units. The Marvell Medical Clinic also offered free sports physicals to more than 550 students, and 219 people who were either private citizens or representatives of area businesses received CPR certification. More than 60 people received

certification in first aid. Finally, the Area Health Education Centers in Pine Bluff and Fayetteville have committed to sending family practice medical residents to the Helena Regional Medical Center and to the Marvell Medical Clinic. These residents spend 1 or 2 months on the rural rotation. To date, three residents have completed rotations. The clinic also serves as a teaching site for the Phillips County Community College through the University of Arkansas' associate degree nursing program and for its medical office staff program. So far, 45 students have rotated through the Marvell Medical Clinic.

The most valuable lesson learned was that, by working together to reach a common goal, a community can solve its own health problems. For example, before the grant, Marvell did not have its own sources of health care, but thanks to the leadership of local government, the community took it on itself to generate the health care sources it needed. The struggle was difficult and filled with challenges along the way, but the community did not give up. Another important lesson was the need for good communication among the consortium members. At times, had the lines of communication been more open, some minor problems could have been resolved more quickly.

Potential for Replication

This model of care can work in any community where citizens are ready to take ownership of their own health care problems and are willing to work together. Most rural areas have similar problems—lack of primary medical care, transportation problems, lack of activities for senior citizens, and a shortage of health education efforts. However, a medical clinic that is designed, owned, and operated by the community can be an effective solution to these problems.

DHEC has developed a nine-step methodology for creating a medical clinic in other rural areas:

- Find an initiator—a champion of the cause.
- Identify the issue that needs to be addressed.
- Gain support, perhaps through the efforts of a working group.
- Compile a list of the community's health care assets.
- Develop an action plan.
- Encourage and promote participation.
- Communicate with the public.
- Implement changes that will increase the likelihood of success.
- Monitor and evaluate the program, and adapt when necessary.

Although people in the community may be reluctant to try something new, generating trust and giving the community ownership of the service can be powerful tools in achieving success.

After the Grant

Most of the activities supported by the grant will continue. The van service is being operated by HRMC but is assigned to the Marvell Medical Clinic. The interactive video is funded by HRMC and the University of Arkansas for Medical Sciences Regional Program. HRMC has also requested that the newsletter continue to be published and mailed to the 1,900 households in Marvell and the surrounding area.

The project coordinator is still employed by DHEC and continues to coordinate the van service, medical consultations, publication of the newsletter, and the Classics group. Most of the other programs will be supported by DHEC. In addition, the University of Arkansas for Medical Sciences and the Phillips County Community College, through the University of Arkansas, will continue to provide student rotations through the clinic.

IOWA

THE ASSURE PROJECT
WASHINGTON COUNTY SCHOOL DISTRICT

WASHINGTON, IOWA

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Population Served

The ASSURE Project was designed to ensure that all children and adolescents in Iowa's Washington County have access to mental health and substance abuse treatment services. The programs targeted the *unserved* mental health needs of the Hispanic and low-income population and the *underserved* mental health needs of the general population of children and youth in Washington County.

Washington County is 1 of only 2 of Iowa's 99 counties not served by a Community Mental Health Center. At the time of the project's creation, no psychiatrists were located in the county, and many children and families had to travel to other parts of the State for mental health services. In addition, there were no substance abuse treatment services in the county.

Services Provided

Through the ASSURE Project, six partners combined their resources to form the Washington County Mental Health Consortium. The agencies included the Washington County School District, which coordinated the project; Higher Plan, Inc.; Washington County Hospital; Lutheran Social Services; Mid-Eastern Council on Chemical Abuse; and Psychological Services, PC. Together, these agencies provided mental health services to children and adolescents throughout the county using a school-based approach.

Through ASSURE, project staff members developed new sites for the delivery of mental health services in cooperation with Washington County's existing health care agencies. All the services provided by this project were either new services in the county or were an expansion of current services. Some of the new services included:

- Child and adolescent psychiatric services in the county
- An incounty psychiatric medication clinic for children and adolescents
- Group and family therapy services for children and adolescents and their families
- Substance abuse treatment services in the county
- Transportation assistance to mental health and other health services
- Outreach mental health services to low-income families

- Culturally appropriate outreach mental health and basic health services offered in Spanish to Hispanic families
- Communitywide mental health case management services.

County services expanded under this project included:

- Child and adolescent psychological services
- Individual mental health therapy
- Basic health services outreach to low-income families
- Substance abuse assessment services
- Crisis intervention services
- Referral to other community-based health services.

The school system was used as a connecting point for children and families. This project allowed mental health providers in the community to work closely with school staff to identify those students in need of assistance and to coordinate treatment with ancillary support activities that took place during the school day. In addition, the project provided mental health services during evening hours, including extensive therapy and psychiatric services. This allowed a far greater number of residents to obtain care in the community.

ASSURE supported the first board-certified child psychiatrist to provide treatment in the county, first substance abuse treatment services in the county, and first bilingual (English-Spanish) outreach worker to provide services in the Spanish-speaking community.

All staff members participated in monthly meetings to provide group supervision and to coordinate project activities. Each consortium member submitted quarterly progress reports and used 2 E.A.S.Y. database software to track all client contacts and services. An independent third-party evaluator was responsible for analyzing and reporting project data.

Innovative Solutions to Problems

As with many community-based programs, the ASSURE Project suffered from a lack of staff time and resources. Identifying a large number of children and families with significant mental health needs was not nearly as difficult as finding someone to provide care. ASSURE's child psychiatrist was available only 1 evening per week because of funding limitations. To ensure that many children and families were served, the child psychiatrist worked closely with the mental health therapist to develop treatment plans and in carefully monitoring the process of ongoing treatment.

The ASSURE Project also had difficulty recruiting a substance abuse treatment counselor willing to work full time in Washington County. Substance abuse treatment services in the region are coordinated by an agency that serves a five-county area, of which Washington County is the farthest from the home

office. After the first substance abuse staff person left the project to transfer to a different county, project staff members worked carefully with the substance abuse treatment agency to recruit and hire a staff person who would commit to staying in Washington County for the duration of the project.

Although consortium members struggled to work effectively with the school at the beginning of the project, continued efforts eventually resulted in clear lines of communication between the school system and social service agencies throughout the county. The consortium continues to struggle with the recruitment and retention of staff who will stay in a rural area for an extended period; however, significant progress has been made in educating school district staff about the value of school-based health and mental health services and the role of the education system in providing these services.

> "THE MOST SIGNIFICANT LESSON WE LEARNED FROM THE EVALUATION IS THAT THE MORE SERVICES ARE TAILORED TO MEET THE INDIVIDUAL NEEDS OF THE CHILD, THE MORE SUCCESSFUL THE CHILD WILL BE. WHILE THIS IS NOT A NEW CONCEPT, IT CONFIRMS OUR BELIEF THAT THE TRADITIONAL WAY OF DELIVERY FOR MENTAL HEALTH SERVICES MAY NOT BE THE MOST EFFECTIVE. THESE ARE STUDENTS WHO HAD NOT BEEN SUCCESSFUL IN THE PAST WHO ARE NOW SIGNIFICANTLY MORE SUCCESSFUL IN SCHOOL AND AT HOME."
>
> TOM LEWIS
> DIRECTOR OF GRANTS
> WASHINGTON COMMUNITY SCHOOL DISTRICT

Results

According to the project's most recent evaluation report, ASSURE successfully achieved all three of its goals—healthier children, involved parents, and inclusive and committed schools. All children in the school district needing mental health services have obtained services, regardless of the family's ability to pay. The children served by ASSURE have missed fewer school days, have improved their academic performance, and are able to interact more successfully with peers and adults. ASSURE also actively engaged and assisted parents in supporting their children throughout the treatment process.

The project was particularly successful in engaging Washington County's Spanish-speaking population, which has traditionally received little or no mental health services. Although many Spanish-speaking youth are able to speak English quite well, the majority of Spanish-speaking adults in the county cannot. ASSURE offered all information, training sessions, and support services for parents and adults in Spanish. As a result, Spanish-speaking parents in Washington County are more connected to the school district, have a better understanding of what they can do to help their children, and are significantly more involved in the daily lives of their children at school.

Finally, the ASSURE Project played a key role in uniting local social service and health agencies. ASSURE has emerged as a model of effective interagency planning and collaboration for school-based mental health services and is being used by other social service agencies to work with school districts on a variety of other projects.

Potential for Replication

ASSURE's approach to mental health services involves making schools the connecting point for students and their families and carefully tailoring services to individual needs. The Iowa Department of Education is now supporting the creation of school-based youth service programs throughout the State. Nearly 30 sites have received funding to create "one-stop-shopping" centers, and ASSURE is being viewed by many as a model for the delivery of school-based mental health services.

Other communities, however, may have some difficulty in building close working relationships between schools and mental health and social service agencies. Lack of understanding on how other groups operate may jeopardize the ability of agencies to work together effectively. Nevertheless, the ASSURE Project stands as proof that it can be done.

After the Grant

Most of the consortium members continue to work together to expand school-based service programs. To date, ASSURE has obtained $150,000 from the Iowa Department of Education and $89,000 from the Wellmark Foundation to expand current school-based services to include health care assessment, treatment, and case management for all children in Washington County. All three school districts in Washington County have joined the consortium and are making significant in-kind and staff contributions to sustain children's mental health services and to expand these services countywide.

Population Served

Harlan County is located in the central Appalachian Mountains of southeastern Kentucky and has 467 square miles of twisting, mountainous roads. It has an average population density of only 78 people per square mile, with 84 percent of the population residing in rural, mountainous regions. In the 1990 census, roughly one in nine households did not own a vehicle or have access to reliable transportation. Harlan County offers only a limited public transportation system.

The poverty rate in Harlan County is more than 33 percent—significantly higher than Kentucky's poverty rate of 19 percent and the 13 percent national average. In 1990, 30 percent of the county's population was considered among the working poor, with an income below 185 percent of the poverty level and a per capita income of $7,500.

Despite the availability of numerous health programs and services, many residents do not access or use these services appropriately. Many Harlan County residents do not know where, when, and how to seek health care services. There is also a dire shortage of health care providers and jobs with health care insurance coverage. These factors are compounded by the fact that Harlan County residents are typically proud people who prefer to live as independently as possible and are skeptical of "outsiders."

This is the service environment in which the Harlan County Homeplace operates. Of those served as a result of the Rural Health Outreach Grant, nearly two-thirds were adults between ages 20 and 64, one-quarter were elderly residents, 13 percent were children and adolescents, and the vast majority (80 percent) were female. These clients are typical of those in the community who have fallen through the cracks either because they did not meet stringent requirements set by area service providers or because they simply did not understand how to navigate the system to receive the needed services. The majority of the services provided with grant funds included affordable medication; free or low-cost primary health care; vision services; dental care; and assistance in meeting basic needs, such as food, clothing, and shelter.

KENTUCKY

HARLAN COUNTY HOMEPLACE
CLOVER FORK CLINIC

EVARTS, KENTUCKY

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Services Provided

The primary goals of the Harlan County Homeplace were to:

- Increase access to health care services by promoting appropriate use of preventive services
- Identify individuals and families unable to access health care
- Work to eliminate barriers to care
- Assist families in accessing primary care, mental health services, and social services
- Strengthen existing networks for people needing information and referrals
- Improve the overall health of the entire family.

The Harlan County Homeplace used 10 specially trained health care advisers (HCAs) as its primary outreach mechanism. These individuals had lived in the community for many years, knew the people and the culture, understood the problems and barriers that Harlan County residents face, shared similar life experiences and socioeconomic backgrounds, and were able to quickly gain the trust of local residents. After conducting home visits to assess a family's needs, the HCAs linked families with available community resources to help bridge the gap between available services and families. The Harlan County Homeplace also emphasized education, prevention, and support, allowing HCAs to establish trust with clients and ultimately having a positive impact on their health.

Once individuals and families were engaged, they immediately gained access to a broad range of health care and support services made possible by a consortium of 16 different county agencies, businesses, and groups, including education, social, health, business, religious, and citizen interests. Together, these organizations contributed more than $700,000 in in-kind services, enabling numerous uninsured individuals to access free or affordable care.

The program assumed a visible role at all levels of community life by participating in a variety of community functions and committees. For example, the Harlan County Homeplace formed a Breast Cancer Awareness Team to conduct presentations throughout the region. It also coordinated and participated in a dental outreach effort and provided representatives to serve on several local committees, including the Elder Task Force, Interagency Council, Domestic Violence Task Force, Welfare Reform Action Team, and many others. The program also developed a County Resource Manual, which provides information on resources available within the county and how to access those services.

Innovative Solutions to Problems

Although the program achieved significant progress in improving the health status of many people throughout Harlan County, many local challenges could not be addressed due to the short duration of the demonstration. For example,

although many local programs and services are available to meet the needs of children, little is available to address the needs of adults—the elderly in particular. In Harlan County, as in many rural areas, there are a vast number of elderly individuals who cannot afford the vital, life-sustaining medications they need. Often, they must choose between eating or taking their medication. In addition, many elderly residents did not have the family support they needed to ensure that they took medications as prescribed and visited the doctor regularly.

Results

Through a strong, collaborative effort with various agencies and health care providers throughout the county, Harlan County Homeplace not only *met* but also *surpassed* its goals. In the first 2 years of the grant, program staff handled more than 3,000 cases, conducted 4,755 home visits, made nearly 8,000 telephone contacts, and provided nearly 600 brief encounters. During this time, more than 4,500 problems were addressed, with nearly 90 percent achieving a positive outcome. Harlan County Homeplace also helped more than 700 clients access more than $250,000 in free medications, averaging a savings of approximately $400 per client.

Potential for Replication

With a great deal of planning, organization, and forethought, any rural community could benefit from a program using lay workers and home visits. It is important to ensure that the program includes planning, community needs assessments, and the formation of a strong network. Most important for Harlan County Homeplace was the broad-based support it enjoyed throughout the community before it even got started.

After the Grant

Once the Rural Health Outreach Grant funds were spent, program staff members were unable to secure funding to sustain the program at its full level; however, they are working with the statewide program, Kentucky Homeplace, to find a way to expand the statewide program to Harlan County. If unsuccessful, Harlan County Homeplace will not be able to continue to provide services to this community.

LOUISIANA

CONCORDIA RURAL SERVICES PROJECT

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Population Served

Rural Louisiana has historically been plagued by cyclical poverty and extremely high incidences of diseases—many of which are preventable. The Concordia Rural Services Project was designed to serve six rural parishes in central Louisiana that generally lack access to basic, yet critical, health care services.

Services Provided

The goal of the Concordia Rural Services Project was to enhance and expand the existing community outreach program for alcohol- and drug-dependent individuals to ensure access to a full range of health care services through improved coordination of existing resources, linkages to distant services, and the development of direct care services.

The consortium included the Concordia Substance Abuse Council, operating a detox facility in Ferriday and serving as the lead agency for the project; the Region VI Office for Addictive Disorders, providing six "satellite" outreach clinics for the project; the State Office of Public Health, providing educational materials, immunizations for children, tuberculosis (TB) treatment, and assessments and referrals; the Office of Mental Health, serving clients either in their own community or at existing regional facilities; the Office of Community Services, serving predominantly women and children and, in cases of child abuse, making referrals to appropriate treatment; and the Huey P. Long Memorial Hospital, serving indigent individuals and people with severe mental disorders.

Together, the consortium members:

- Provided education on pregnancy, sexually transmitted diseases, and other communicable diseases at schools, in community groups, within town governments, and at housing projects and to clients referred by the judicial, public health, mental health, substance abuse, and child protection systems
- Worked to increase public awareness of nutrition, prenatal care, substance abuse, and childhood immunization and diseases and launched public awareness campaigns on the major causes of death in each community
- Provided prenatal screening, monitoring, and counseling, with strong emphasis on reaching the African-American community

- Offered psychological and health-related counseling on teen pregnancy
- Provided transportation and educated the community about available services
- Created a toll-free number for information and for referrals to prevention, education, and service agencies.

The project disseminated information on HIV/AIDS and other sexually transmitted diseases throughout the service area. TB and HIV testing were offered at health fairs; in the housing projects and public businesses; at condom distribution sites, jails and prisons, churches, neighborhood centers, child-care facilities, and Head Start programs; and to individuals on the street. In fact, the TB screenings offered throughout the area showed that the community was experiencing a TB epidemic. Citizens who tested positive were referred to the Office of Public Health for followup care.

Innovative Solutions to Problems

Using outreach workers to educate and engage clients is not a new idea. However, the Concordia Rural Services Project took the concept a few steps further. Because the substance abuse outreach clinics had already been established through a grant from the Center for Substance Abuse Treatment, the duties of outreach workers were expanded to include street outreach, condom distribution, health education on safer sexual practices and disease prevention, substance abuse education, and tobacco use prevention. In other words, the project did not wait for clients to come to it; the outreach workers went out onto the streets and met clients on their own "turf." Outreach workers also educated local merchants about the Synar initiative (which is geared toward reducing illegal tobacco sales to minors) and about the consequences of selling tobacco products to underage residents. Local teenagers participated in compliance checks to see whether local merchants would sell them tobacco products. Merchants who refused were given a certificate of appreciation. Those who sold tobacco to minors were warned that if there had been a true compliance check, they would have been fined.

Another unique feature of the project was the purchase of three vans used to transport clients to and from medical, psychological, substance abuse, and dental services. When necessary, transportation was provided to clients throughout the six-parish service area.

The "Baby Think It Over" project encountered some major obstacles. Competition by a local nonprofit agency recipient of a Federal grant to conduct a "Baby Think It Over" project in all of central Louisiana's schools prohibited the Concordia Rural Services Project from entering local schools to communicate a

broader health education message. Instead, Concordia presented its program to church youth groups, Girl Scouts, 4-H clubs, cheerleaders, and basketball programs.

Results

One of the most encouraging results of the project was the confirmation that agencies focusing on a particular public health need—such as substance abuse, mental health, or primary care—can successfully broaden to a more comprehensive health care system through effective case management. Moreover, the project confirmed the importance of having a lead agency that champions the need for services in rural areas. In this case, the Office of Alcohol and Drug Abuse provided local advocacy and fiscal support and made it possible for the outreach model to be used in the six-parish area. It also played a major role in ensuring effective coordination of services by developing strong referral relationships and linkages with area service providers.

Another major accomplishment of the project was that it assisted the State Office for Addictive Disorders in getting all the outreach satellite clinics licensed by the State of Louisiana. This new standing allowed the clinics to continue operating after grant funding expired and afforded them more "clout" when pursuing new funding opportunities.

Notwithstanding the successes of the project, providing mental health services remained a serious challenge throughout the grant period. The Office of Mental Health has faced budget cuts in recent years, making the impossible to treat many of the dually diagnosed clients and limiting its efforts to serving people with severe mental illness. There are no dual-diagnosis inpatient facilities in the six-parish area or in the entire State of Louisiana.

The outreach model was effective in educating and engaging clients in a nonthreatening manner and in providing university evaluators and State administrators with a "reality check" as to what would most likely work best in engaging clients. However, the evaluation process revealed that alcohol abuse and systemic poverty remain daunting challenges for the region. In addition, transportation continues to be a barrier to accessing services and school-based prevention programs.

Potential for Replication

This outreach model can be easily duplicated. It is critically important, however, to hire outreach workers who are members of the targeted service area, largely because rural communities simply do not trust "outsiders." A case in

point—one substance abuse clinic that had had no clients was able to treat 40 individuals within a 3-month span once an outreach worker from the community was hired.

It may also be a good idea to limit the service area. Consortium members that are close to each other and share a common agenda are easier to manage. The large service area for this project made it difficult to focus on just one community. The formation of smaller decentralized teams within each community or parish gave hands-on management responsibility to local consortium members, creating the flexibility to respond effectively to changing community needs.

After the Grant

The Office for Addictive Disorders agreed to continue funding outreach efforts through a contract with the Concordia Substance Abuse Council. HIV/AIDS testing, pregnancy prevention, teen smoking prevention, and substance abuse prevention efforts are being funded by the State, and the vans purchased with grant funds will continue to provide transportation for rural residents who need it.

Population Served

Located in Massachusetts' Northern Berkshires, the North Quabbin, and Lower/Outer Cape Cod, Healthy Connections targeted 26 communities with a combined population of nearly 112,000 people. Many residents in these communities had little or no health insurance, and at the time of the grant award, there were no organizations or programs specifically focused on assisting people in locating and enrolling in health coverage programs.

Services Provided

The purpose of this program was to provide outreach and enrollment services to uninsured and underinsured rural residents. This included helping parents enroll their children in the State Children's Health Insurance Program, educating residents about their health care options, and providing followup to ensure that clients were successfully enrolled in and connected to the services they needed. Healthy Connections staff members also provided referrals to a range of health and human services, such as fuel assistance, food stamps, transportation, and other supports.

The Healthy Connection consortium consists of 11 service providers, community coalitions, and statewide organizations. The three service providers—Outer Cape Health Services, Athol Memorial Home Health and Hospice, and Ecu-Health Care/ Northern Berkshire Community Coalition—provided field-based outreach and enrollment services. Outreach workers assisted residents in enrolling in publicly funded health programs and in accessing other needed community-based services. Area Health Education Center/Community Partners coordinated the statewide effort, assisting each provider organization in implementing the programs.

Each Healthy Connections site was supported by a regional community coalition. These coalitions provided access to a range of community resources and highlighted health care access issues that arose during the outreach process. The statewide organizations—Health Care For All, a statewide health advocacy group; the Office of Community Programs at the University of Massachusetts Medical School; and the Massachusetts Department of Public Health—provided overall program guidance and strategic expertise.

MASSACHUSETTS

HEALTHY CONNECTIONS OUTER CAPE HEALTH SERVICES, INC.

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PROJECT 6—HEALTHY CONNECTIONS

What made Healthy Connections unique was the combination of community-based outreach—a common component of public health programs—with a health insurance enrollment initiative. The program focused on hiring staff from the community who knew where to find those who might need services and who would be able to link residents to local resources. Outreach was done where people worked and lived, enabling the program to provide meaningful and effective assistance.

The program also placed strong emphasis on client followup. To ensure that residents were successfully enrolled in programs such as Medicaid, program staff members kept in regular contact with clients by telephone and mail or by home visits whenever necessary.

Innovative Solutions to Problems

Logistics and coordination were the primary barriers to establishing a statewide rural outreach program. Outreach staff members' time was limited because they were employed part time. Therefore, they found it difficult to remain informed of new program developments or to coordinate their activities with other outreach workers. To remedy this situation, the program director began conducting site visits to update staff on program developments. In addition, the program sites began using e-mail to communicate with one another and to coordinate activities.

Another problem faced by the program was that, shortly before the program was launched, one of the consortium service providers withdrew because of a reorganization. Consequently, another consortium member, the Community Coalition, had to assume the added responsibility for outreach and enrollment efforts in the Northern Berkshire area. Although, this challenge did not significantly affect program operations, it required careful monitoring and clear delineation of roles.

Results

Between March 1997 and June 1999, Healthy Connections served 4,370 individuals from 2,619 rural Massachusetts households. Of those served, 98 percent expressed satisfaction with the services they received, and 95 percent said they would recommend the program to others. These findings were consistent across all three service sites. The program also discovered that followup was essential to successful enrollment, especially in complex and bureaucratic systems such as Medicaid.

In addition to providing outreach, enrollment, and referrals to health care services, Healthy Connections played a major role in drawing attention to existing gaps in health care access as well as the barriers preventing residents from receiving the care they needed. In many cases, Healthy Connections served as the catalyst in mobilizing the community to increase health care access. It also succeeded in generating new sources of revenue, enabling the program to sustain operations after grant funding expired.

Potential for Replication

Massachusetts' State-funded Health Access Mini-Grant Program was modeled after Healthy Connections. Given that the State and Federal governments have both identified enrolling children and families without health insurance as important goals, Healthy Connections would be a promising model for any rural community seeking to implement this type of program.

However, communities and organizations seeking to use this model must recognize that program success hinges on effective outreach. Outreach workers must gain the trust of those they serve and must respect residents' concerns, cultures, and needs. Whenever possible, outreach workers should come from the target community. Outreach should be conducted where people live and work, and services should be provided at times and locations that are convenient for the client.

After the Grant

Healthy Connections achieved sustainability because the program successfully made its services an integral part of each community's health and human service continuum. Some of the core outreach and enrollment activities are supported by State funds. The program has also applied for additional grant funding so that outreach and enrollment efforts can be expanded to include more extensive followup and new linkages to health care services.

MICHIGAN

HEALTH OUTREACH PROJECT
B-H-K CHILD DEVELOPMENT BOARD

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Population Served

The Health Outreach Project (HOP) focused on increasing childhood immunization rates among children in Baraga, Houghton, and Keweenaw counties—all of which are located on a peninsula in the northernmost region of Michigan. The area is known as "copper country" because copper mining was once the primary source of the region's economic prosperity. It covers 25,000 square miles and is home to 47,000 people—of whom roughly 3,300 are children younger than age 6. Since the last copper mines closed in 1968, residents have endured more that three decades of high unemployment and severely limited access to health care and support services.

Approximately 40 percent of copper country children are Medicaid-eligible, but the lack of public transportation, the distance from services, and harsh winters make access to immunizations and other well-child services difficult. In the mid-1990s, Michigan's childhood immunization rates ranked as the worst in the Nation. At the beginning of the project, nearly 4 of 10 children in this sparsely populated, three-county area were not protected from serious and preventable illnesses.

Services Provided

HOP resulted from a public/private partnership of local organizations and schools. The lead agency, the B-H-K Child Development Board (B-H-K), is a nonprofit provider of Head Start, preschool, child care, and family support programs that serve 600 families. The consortium also included the Western Upper Peninsula District Health Department, which is a public health agency serving five western Michigan counties and three local school districts within those counties.

B-H-K managed all administrative and fiscal responsibilities associated with the program and conducted outreach. The health department created a computerized immunization registry and gleaned data from immunization records. The school districts hosted the outreach workers and linked children and families to immunization services. Keweenaw Family Resource Center, a private nonprofit organization, was contracted to make initial hospital

"RUNNING SMALL PROJECTS IN SMALL TOWNS IS ALL ABOUT GETTING THE RIGHT PEOPLE TOGETHER."

DR. M. GAIL SHEBUSKI
MEDICAL DIRECTOR
WESTERN UPPER PENINSULA
DISTRICT HEALTH DEPARTMENT

visits with families of newborns to ensure that they were enrolled in the HOP registry; home visits to these families began in April 1997.

Between January 1998 and July 1999, 2,256 children were enrolled in the HOP immunization registry. Most were children ages 0 to 6. More than 700 children were newborns and their siblings enrolled through home visits or through other contacts by outreach workers. More than 1,500 became enrolled in preschool and kindergarten programs. The program also sent more than 3,700 letters to parents to inform them about their children's eligibility to receive shots or to notify them that immunizations were overdue.

Outreach workers played a key role in informing parents and children about immunization, nutrition, safety, and other prevention or health-specific topics during home visits and in presentations to preschool and elementary school classes as well as to parent groups. They also tracked and reported immunization rates for schools and assisted B-H-K in providing free health and development screenings and other well-child services.

Parents of newborns learned about HOP from outreach workers while still in the hospital (at the same time that the first hepatitis B vaccine is usually given). Followup home visits were made by outreach workers when the babies were approximately 1 month old. This was a crucial time to enroll children in the immunization registry because additional immunizations were due at 2 months of age. By meeting the parents in the hospital and by visiting them at their homes, outreach workers were able to develop a personal relationship with families, which helped cultivate a spirit of trust.

Outreach workers were also active in local schools and participated as members of the school's staff. By being actively involved in school life, outreach workers were able to establish one-on-one relationships with rural families and to use that relationship as a means to talk to parents and families about immunization and the importance of prevention.

Innovative Solutions to Problems

Developing a registry of children and families is not as simple as it may sound. When the project first started, local immunization providers were using different data-tracking systems, and all of the information had to be pooled into one database. Although it is fairly easy to track what immunizations are given to which children, it is difficult to ensure the accuracy of the records when information comes from several different sources.

Throughout the first year of the project, the program lacked focus and direction. Initially, the program was intended to provide health education in schools, in child-care agencies, and throughout the community. However, by the

end of the first year, project staff members decided to shift the program's focus to increasing immunization rates in the targeted area. Within 3 months, the immunization registry was up and running.

Another major challenge to the success of the program was recruiting children and families to participate in the HOP. The program contracted with the Keweenaw Family Resource Center, which operated a hospital visitation program, to recruit eligible children and families while in the hospital. The center received compensation for every family that accepted a referral to the outreach program; this strategy ensured a 90-percent success rate.

Results

As a result of the coordinated community efforts led by HOP, local immunization rates improved dramatically. As of July 1999, 90 percent of HOP-enrolled children ages 19 to 35 months were fully immunized, compared with nearly 62 percent of other children the same age listed in the health department's database. Immunization rates were similar for children who received shots from public clinics or private providers, indicating that participation in HOP was the key factor in raising local immunization rates. HOP showed that it is possible to engage rural communities in prevention efforts by contacting families when a child is born and by making followup contacts.

Potential for Replication

This outreach model should be easily replicable for other rural communities seeking to increase child immunization rates and other health improvement efforts targeting children and families. For example, communities that want to reduce the incidence of lead poisoning could develop a registry of infants at birth, use outreach workers to provide information to families about lead poisoning, and track individual child blood-lead test results. Outreach efforts that emphasize developing a personal relationship between outreach workers and families can be an effective way to address a broad range of public health concerns affecting rural communities.

After the Grant

The consortium plans to continue operating a local immunization registry for at least 1 year or until the statewide Michigan Childhood Immunization Registry is fully operational in copper country. The consortium has also developed a plan to continue providing outreach and registry at a cost of about 40 percent less than the original program cost. School-based outreach efforts will

be limited because funding for outreach is expected to come from the State's Strong Families/Safe Children initiative, which allocates money to county-based programs providing immunizations and other disease prevention efforts.

The Keweenaw Family Resource Center will continue to contact parents of newborns to educate families about the importance of timely immunizations. The health department will also continue to provide monthly data transfers and technical support. B-H-K will manage the immunization registry, conduct outreach to families in the three-county area, and conduct home visits.

MICHIGAN

LOWER RIO GRANDE PROMOTORA COLLABORATION PROJECT

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Population Served

The Promotora Collaboration Project was launched in Texas' Lower Rio Grande Valley, which is located along the Texas-Mexico border. The Lower Rio Grande Valley covers four major counties—Hidalgo, Willacy, Cameron, and Starr. Many of the residents in the target service area are Mexican-Americans who live in unincorporated neighborhoods, called *colonias*, outside the city limits. It is estimated that there are more than 1,000 *colonias* within these four counties.

Colonia residents are typically isolated from primary health care services and basic health information. Often, they live in substandard housing that lacks proper sanitation. The area also suffers from high rates of unemployment, severe poverty, low levels of education, and extremely poor health status.

Services Provided

The project was built on the combined experience and expertise of three consortium members—all of which shared a strong commitment to the value of using *promotoras*, individual health educators who work at a grassroots level to provide basic health education and referrals to primary health care. Migrant Health Promotion, the project's lead agency, provided administrative oversight and managed the *promotora* program. Planned Parenthood also employed *promotoras* to focus on the unique needs of women in the target service area, such as education on reproductive health, family planning, and HIV/AIDS and other sexually transmitted diseases. The third consortium member, Avance, brought to the project an established network of social service providers that possessed a long history of working with *colonia* residents. The three consortium members coordinated their outreach efforts and provided joint training for *promotora* staff.

Specifically, the project focused on individual and group health education sessions, referring *colonia* residents to local health services, providing individual followup, and training *promotoras* to work in a Medicaid managed care environment. Nine *promotoras* were hired to work in the three collaborating agencies, and all *promotoras* provided referrals and followup care.

Innovative Solutions to Problems

Almost any time that three different organizations join forces to address the same challenge, management and supervision problems will most likely occur. Each organization brings different strengths to the project, and staff members may have different levels of experience and skill. The Promotora Collaboration Project faced many of these challenges. Early in the project, inconsistent management and supervision practices had a direct effect on the project's evaluation, quality assurance, data collection, and analysis processes. However, during the project's second year, things began to change. Migrant Health Promotion started conducting biweekly monitoring visits with each agency to address these differences. The project instituted uniform reporting requirements because part of the problem was the different methods of reporting data. Each *promotora* was then required to complete a referral and followup form to document the referral and to track outcomes.

Another challenge faced by the consortium was the lack of knowledge about managed care and its effect on *promotoras*. Migrant Health Promotion facilitated monthly sessions to inform consortium members about managed care and about policy issues affecting *promotoras*. To ensure that *promotoras* worked effectively with Medicaid managed care, it was necessary to familiarize them with issues such as health outcomes, cost savings, the scope of services, pricing, payment mechanisms, and administrative and managerial skills needed to meet the requirements of managed care organizations. The project provided training on the impact of Medicaid managed care in other Texas communities and invited trainers from these communities to educate *promotoras* about their experiences to meet their challenge. The project also joined forces with the South Texas Community College to develop credentials for *promotoras*.

Results

The Promotora Collaboration Project provided individual health education to more than 12,000 *colonia* residents. It also reached approximately 15,000 individuals through group education sessions, and about 3,500 individuals received referrals to services and followup care. Most of those who received services were women and children.

In addition, while the South Texas Promotora Association (STPA) began organizing *promotoras* in 1993 as the Promotora Task Force, this project played a major role in helping STPA assume a stronger leadership role within the community. The project also provided 302 training hours for the *promotoras* who participated in the program.

Potential for Replication

The use of *promotoras* as health educators and frontline brokers of care proved to be a successful approach to increasing access to basic health care services and to improving health status through education. Although this model of care can be easily replicated in other communities serving Hispanic/Latino populations, program staff members offer the following tips to increase the likelihood of success:

- Assess agency and staff readiness to support the *promotora* model and to implement it successfully. Allow 6 to 8 months for program development and staff orientation.
- Establish uniform data reporting requirements before the project starts.
- Develop consistent supervision and quality assurance procedures for *promotoras* working in different agencies.
- Employ a project director who knows how to build a coalition and how to coordinate services across agencies.
- Identify the specific roles and responsibilities of consortium agencies.
- Be knowledgeable of health care and related policy issues affecting the community and the target population.
- Do not duplicate. Find out who is already doing what in the community. Work in close partnership to leverage limited resources wisely and efficiently.

After the Grant

The Promotora Collaboration Project will continue to provide coordinated outreach activities in the Lower Rio Grande Valley, in part because of the consortium's commitment to working together in the future and because of the availability of additional grant funds from other sources. Consortium agencies will continue to meet once a month to facilitate *promotora* training and to remain informed about emerging issues—such as health care policy, managed care, and *promotora* legislation—that may affect the population and the delivery of services.

Population Served

Sections of south-central Minnesota have undergone rapid and dramatic demographic changes. Large-scale growth in the region's Hispanic population has led to mutual cross-cultural misunderstandings, racial tensions, and irrational fears between older non-Hispanic residents and new Hispanic arrivals. The health status of the area's Hispanic population is virtually unknown, and most Hispanic families lack a regular health care provider and tend to seek care on an episodic basis. Hispanic families face language and cultural barriers when they interact with area health care providers, who are predominantly Anglo-Saxon. Furthermore, linguistically and culturally appropriate health education and disease prevention materials do not exist.

This project specifically targeted two counties in south-central Minnesota—Sibley and Watonwan. Both counties have the largest number of Hispanic families living below the poverty level in the State, with a high concentration of female-headed households with children younger than 18. Some segments of the Hispanic population are highly transitory, making it difficult to recruit and engage them in service delivery.

Services Provided

Saludando Salud was designed to achieve two health-specific objectives—to increase access to basic health care services among the region's Hispanic population and to increase appropriate utilization of health care services. To achieve these goals, the program outlined four strategic objectives:

- Provide coordinated health outreach and medical interpretation services to Hispanic/Latino families and others living in the target area.
- Promote healthy lifestyles, individual responsibility for health, and management of chronic health conditions.
- Prevent and reduce the incidence of substance abuse and other health problems among the target population.
- Provide intensive cultural competency training to health care and social service providers.

MINNESOTA

SALUDANDO SALUD REGION NINE PREVENTION AND HEALTHY COMMUNITIES

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The Region Nine Development Commission served as the project's lead agency by providing coordination and oversight and by sponsoring health promotion activities. Other consortium members included the Life Work Planning Center, which coordinated health outreach efforts; the Sibley and Watonwan public health agencies; Arlington Hospital; St. James Health Services, Inc.; and Madelia Community Hospital. Consortium members also participated in an advisory committee, which included a 50-percent Hispanic representation. The consortium provided bilingual and bicultural outreach workers to make appointments, coordinate referrals, promote services, conduct followup, schedule interpreters, and administer the health survey. It also provided training for medical interpreters, linguistically and culturally appropriate health promotion and disease prevention education, cultural competency training, and a resource center for information and materials.

Innovative Solutions to Problems

In spite of the compelling health care needs of Hispanic/Latino residents in Sibley and Watonwan Counties, the project initially suffered from a lack of community support as well as from distrust from the Hispanic community. To overcome this challenge, program staff members met with community leaders, organizations, and local agencies to help "sell" the project. As members of the Hispanic community started receiving care that met both their medical and cultural expectations, the project began to gain the respect and trust of the community.

One of the unique features of Saludando Salud was the implementation of a Hispanic/Latino Health Survey. Given the lack of data on the status of Hispanic health throughout the region and that previous efforts to collect Hispanic-specific data were unsuccessful, the survey was developed in both English and Spanish, and outreach workers conducted the survey in a one-on-one client interview.

Bilingual/bicultural outreach workers were a bold innovation for this region and represented a vital component of the overall program. Saludando Salud outreach workers served as the link between clients and area health care providers, which laid the foundation for consortium members to develop an ongoing relationship with their Latino patients and to ensure that their needs were met.

Training was also an important program component. Trained medical interpreters participated in client appointments to facilitate communication between the provider and the client. Interpreters often scheduled followup visits with clients and provided transportation to and from appointments. The program also supported cultural competency training for providers by tailoring a series of workshops for consortium members.

The program actively worked to develop appropriate health promotion and disease prevention programs throughout the community. In addition to offering health education workshops in Spanish, organizing a Latina Health Fair, sponsoring a Hispanic Health Forum, and developing Spanish-language materials, the program also created a weekly radio show titled "La Hora de la Salud." This 1-hour radio show, produced in Spanish, was broadcast every Saturday afternoon. The program included music, educational *radionovellas*, guests, health news, announcements, and public participation.

Results

Saludando Salud served more than 2,000 clients from 550 families. The workshops, health fairs, and health forums reached more than 300 individuals, and the radio show reached as many as 3,000 listeners each week. The project also trained 34 medical interpreters and provided cultural competency training to more than 200 health care providers.

The Hispanic/Latino Health Survey also succeeded in identifying specific barriers to health care for the area's Hispanic population. Nearly 33 percent of respondents identified cost of care as the biggest barrier to receiving services, 27 percent pointed to language barriers, and 12 percent said that transportation was the primary barrier.

Potential for Replication

This service model could be easily applied to any racial/ethnic minority group in a rural community. Lessons learned indicate that an organization or agency considering such an effort should take steps to generate broad-based community support, be prepared to experience resistance to change, and be prepared to address a shortage of bilingual and bicultural health professionals.

> "WE LEARNED HOW IMPORTANT IT IS TO HAVE THE EVALUATION PLAN AND PROCESS IN PLACE BEFORE STARTING ANY PROJECT. FROM THE EVALUATION PROCESS ITSELF, WE LEARNED HOW TO USE IT TO REDIRECT EFFORTS TO BE MORE EFFICIENT."
>
> ANNE GANEY
> PROJECT DIRECTOR
> REGION NINE PREVENTION AND HEALTHY COMMUN.TIES

After the Grant

The Region Nine Development Commission has secured funding to continue health promotion activities for another 3 years. In addition, two members of the consortium are sharing a bilingual outreach worker and are integrating outreach into their programs.

Population Served

The Ozark Foothills region is an economically depressed area located in southeast Missouri. It is composed of five counties—Butler, Carter, Reynolds, Ripley, and Wayne—that are some of the poorest in the State and in the Nation. Incomes are low, unemployment rates are among the highest in the State, and four of the five counties are designated as medically underserved areas.

At the time that the Ozark Foothills Child Health Care Program was created, immunization rates for preschool children living in the region were strikingly low. In fact, one of the five counties reported a childhood vaccination rate of approximately 25 percent, meaning that about 75 percent of the county's children were not being fully immunized. Other counties were also vaccinating children at rates significantly lower than the desired 100-percent level.

Services Provided

To address this compelling need, the Ozark Foothills Health Care Consortium was created. It consisted of approximately 25 agencies and organizations representing almost every health care group in the region. The consortium members that proved to be the primary participants in the Child Health Care Program included the Ozark Foothills Regional Planning Commission (Council of Governments), the health centers of the five counties, the Southeast Missouri Area Health Education Center (AHEC), and the region's two main hospitals.

Each consortium member provided varying types of support to the project. The Regional Planning Commission served as the lead agency, administrator, and fiscal agent while also providing transportation and client-tracking services. The five county health centers also were involved in client transportation and patient followup and ultimately emerged as the primary service providers during the course of the project. The AHEC produced brochures on the program's services and sponsored a variety of training and educational sessions on childhood immunization. The local hospitals offered education to new mothers as well as client-tracking services.

MISSOURI

OZARK FOOTHILLS CHILD HEALTH CARE PROGRAM

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Innovative Solutions to Problems

Together, consortium members became a single coherent and coordinated program. When a mother gave birth at one of the local hospitals, she received information about the Child Health Care Program and the importance of timely immunizations. Working with the hospital, the Regional Planning Commission entered the family information into a comprehensive database covering all five counties, which allowed the project to track each child's future immunization history.

The ultimate goal was to ensure that 100 percent of the area's children younger than age 2 received the full range of vaccinations that they need at the appropriate times. This was accomplished by making numerous contacts with the family by letter, telephone, and when necessary, home visits. If a family could not reach an immunization site on its own, transportation was provided by the commission or the family's county health center.

To support these efforts, the AHEC sponsored informational sessions for area doctors, nurses, and other program personnel. These seminars stressed the importance of timely childhood vaccinations and offered information on state-of-the-art advances in the field of immunization.

Results

As of June 30, 1999, Carter, Reynolds, and Ripley Counties had a 97-percent immunization rate. Butler County's rate was 98 percent, and Wayne County had achieved a 99-percent immunization rate. Butler County observed the largest number of immunization visits—more than 4,800—whereas the other four counties combined for nearly 2,900 immunization visits. In all, it is estimated that approximately 2,080 youngsters were served.

This success can be attributed to the cooperation and participation of the consortium partners, which laid the foundation for continued future participation and collaboration after the grant. In fact, because of each consortium member's commitment, the program was able to attack each challenge that arose during the course of the program with meaningful and productive communication, the sharing of resources, and joint problemsolving.

Potential for Replication

The key to making this model work in other rural communities will be the successful creation of a consortium within a service delivery environment usually fragmented and unaccustomed to the idea of working together toward a common goal. Bringing together a network of agencies, institutions, and organizations will

most likely be the biggest challenge that program sponsors in other rural areas will face. However, creating a unified attack to increase local immunization rates can yield tremendous success—as this project has demonstrated.

After the Grant

The Ozark Foothills immunization program continues to serve the five-county area and is funded by the combined resources of the organizations involved. The Regional Planning Commission provides client-tracking, followup, and transportation services, whereas the health centers continue to serve as the primary service providers. Immunizations are also provided at local hospitals and at physicians' offices. In addition, the AHEC continues to sponsor education seminars for local providers.

Population Served

Project HOPE (Health Outreach and Preventive Education) is a Rural Health Outreach Demonstration Program designed to address the underutilization of preventive health services in Washington County, Missouri, a federally designated medically underserved county in the Ozark foothills. At the time of the grant award, there were no nurse practitioners or outreach services available in the 760-square-mile county. Few residents, almost all of whom are Caucasian, were taking advantage of Healthy Children and Youth screenings or breast and cervical cancer screenings. In addition, screenings for adult males or geriatric patients were not available, and no efforts were under way to recruit clients for these screening services.

At the same time, 20 percent of the population, including children, was using unfluoridated city water, and there were no plans to fluoridate existing water systems. Although many county residents suffered from depression, no therapy or counseling services were available in the county. Infants and children needing comprehensive developmental exams were most often referred to academic health centers in St. Louis, and many parents had little knowledge of normal child growth and development. Health education programs in the county, either for patients or providers, were not organized, and area health professionals lacked rural health-specific training opportunities.

Services Provided

Project HOPE supported a nurse practitioner and provided physician outreach services to remote areas of Washington County. The program also provided preventive dental health services, mental health services, child development clinic services, health education for residents and providers, and clinical practicums for health professions students. These services were made possible by the diversity of the Project HOPE consortium. The lead agency, Washington County Memorial Hospital, administered the project and hired staff. St. Louis University provided a nurse practitioner, a clinical nurse specialist, and child development clinical services. It also coordinated student placements and led the evaluation team. The Washington County Health Department assisted with the delivery of services for women and children and provided Project HOPE's office space. The St. Louis Behavioral Medicine Institute

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provided postdoctoral psychology students to deliver mental health services, established a telehealth psychiatric consulting service, and participated in project evaluation. Healthline Management, Inc., established the consortium's billing system. Missouri's Bureau of Dental Health provided water bottles for testing the fluoride content of well water, fluoridation education opportunities for providers, and expert guidance on when and how to proceed with the fluoridation of city water. The Washington County Board for the Handicapped helped recruit clients for the child development clinic. Potosi Family Dental and the dentist, Edward Lake, D.D.S., provided dental sealant applications to school children throughout the county, community education, and guidance in fluoridating water supplies.

All individuals and families receiving services were required to be at or below the 200-percent poverty level, but most clients were 100 percent below the poverty level. Project personnel and equipment were transported by van to all four county school districts and to remote areas of the county to provide Healthy Children and Youth screenings for children 0 to 18 years and breast and cervical cancer screenings for women ages 40 to 65. With the cooperation of school nurses, Project HOPE set up clinics during school hours in all four school districts so that area children could receive physical exams. Mental health counseling services were provided 2 days per week at the Project HOPE office, and telehealth specialists (either a psychologist or psychiatrist) were available when needed.

The Child Development Clinic was open 2 days a week for children identified as exhibiting signs of developmental delay, and children identified with severe development problems were referred out for more appropriate care.

School nurses invited parents to have their children participate in Project HOPE's dental screenings, allowing for the identification of children needing further treatment.

Innovative Solutions to Problems

The most notable innovations of the project were:

- Using a van to bring staff to clients rather than expecting clients in remote areas to arrange their own transportation
- Enlisting the support of school nurses in organizing Healthy Child and Youth screenings in schools
- Sponsoring psychiatric and psychological telehealth conferences
- Supporting outreach workers to recruit clients and to assist with followup care
- Providing care from a multidisciplinary approach by delivering services in conjunction with primary care.

However, the project encountered its share of challenges. Startup of the telehealth consultation service was delayed because program staff members had trouble getting GTE and Bell to determine how they were going to work together to provide the service. There were also computer breakdown problems and unexpected third-party reimbursement issues relating to telehealth costs.

Project staff members also had difficulty meeting the needs of women seeking cancer screenings. Many of these women had not visited a health professional in years, and obtaining free or low-cost care for them from nearby agencies turned out to be a herculean task.

Results

Dental screenings were provided to 80 children through Project HOPE, and 70 received interdisciplinary child development services. Breast and cervical cancer screenings were given to 170 women, 450 patients received mental health counseling services, and 13 patients received telehealth consultation. About 300 area health professionals, teachers, social workers, State prison employees, and other professionals participated in 1 or more of the 11 health education programs targeting service providers. Health education topics covered a variety of issues, ranging from child abuse to methamphetamine use to stress reduction. Another 51 health professions students from a variety of health disciplines, including psychology, general medicine, nurse practitioner, general nursing, social work, and communication disorders, participated in 512 clinical practicum days. In addition, more than 700 area residents attended 1 or more of the 24 health education programs on topics such as breast and cervical cancer control, child development, and smoking cessation.

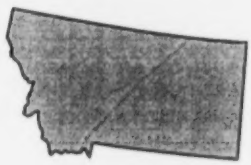
Potential for Replication

One of the reasons why this model was so effective was that the program was located within 80 miles of organizations that could provide nurse practitioner personnel, mental health professionals, and other service providers. Project HOPE staff members indicate that startup funds are necessary to implement such a model and that initial funding should cover the costs associated with the first 5 years of operation rather than the first 3 years. Program planners should also be aware that many clients in rural areas are uninsured or underinsured and that obtaining reimbursement for certain types of services (e.g., telehealth consultation) can be difficult or even impossible. It is also important to determine in advance how the program will address transportation issues because so many clients are isolated from services.

After the Grant

Because the program had remaining grant funds after year 3, Project HOPE received permission to extend its services into a fourth year. In addition, Missouri's State-funded insurance program, MC+, has expanded its eligibility requirements, which will make a broader range of services reimbursable. Meanwhile, Project HOPE is exploring other funding sources, such as foundations and other service agencies, to keep the program operational.

MONTANA



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Population Served

Ashland, Montana, is a small, isolated frontier community in southeastern Montana that borders the Northern Cheyenne Indian Reservation. Although Ashland has only an estimated 484 residents, roughly 1,300 people live within a 50-mile radius, including nearly 500 Native Americans. The local economy is driven primarily by agriculture and timber. The area's population is expected to double in the near future because of the growing coal mining industry.

Before the creation of the Ashland Community Health Center in 1996, medical care was virtually inaccessible to Ashland residents. Although a quick-response unit had been established to provide limited emergency care, it was unable to transport its patients. Emergency personnel called ambulances from a neighboring town, which transported patients to the nearest hospital 80 to 130 miles away. Residents traveled 40 to 100 miles just to see a health care professional, but given that more than 70 percent of Ashland's residents live at or below the poverty level and lack transportation, health care was largely unaffordable and inaccessible. This was especially true during the harsh winter months when mountain roads were at their most treacherous. Native Americans living in the region who were enrolled in their tribe could use Indian Health Services located in Lame Deer, 20 miles to the west. But many Native Americans had no means of transportation.

The area also suffers from high rates of alcohol and drug abuse, teen pregnancy, child neglect, and domestic violence. Moreover, 35 percent of public school children are in special education programs—many of those children were affected by their mothers' use of alcohol and illicit drugs during pregnancy.

Services Provided

The Ashland Community Health Center offers primary medical care, including physicals, prenatal care, drug testing, mental health services, and limited emergency care. Public health nurses focused on maternal and child health services and have provided Women, Infants, and Children (WIC) services to 40 women. The clinic was certified to perform some routine

laboratory tests, although the center has a contract with a major medical center for most laboratory services. The neighboring pharmacy mails prescriptions directly to clients the next day.

In addition to the grantee organization, the Ashland Public School Board, the project's consortium is composed of physicians and physician assistants from four medical centers in surrounding communities who provide care on a rotating schedule. The public health department provides a nurse and a dietitian, and a mental health care provider is available for clients 1 day per week. An advisory committee meets once every quarter to review policy and to provide an annual quality assurance review of clinic operations.

Innovative Solutions to Problems

Many newly funded programs hire health care providers to serve the targeted population. However, the Ashland Community Health Center invited physicians and physician assistants from neighboring clinics to provide care in the clinic once or twice a week. Rosebud County agreed to provide public health nurses and WIC personnel twice a week if provided with the necessary space at the clinic to meet clients. The mental health counselor provided services at the clinic once a week, free of charge, in exchange for the parent organization's membership in the consortium. The public school assumed responsibility for overall project management, with the school nurse serving as the project director.

Public health nurses provide family planning and counseling to teens to reduce teen pregnancy. The WIC program educates pregnant women, nursing mothers, and women with small children about good nutrition. Isolation and lack of transportation make it difficult to access services. Before the Ashland Community Health Center came into existence, women had to travel 20 to 40 miles to receive these services, but most were not either willing or able to make the long trip for these services.

One of the biggest challenges faced at the outset of the program was finding a suitable facility. The project secured $305,000 in funding from other sources to build a new facility and obtained an additional $50,000 to install an elevator so that the basement could house a conference room, the telemedicine center, and private rooms for staff to meet one-on-one with clients.

Results

The clinic had more than 3,000 patient encounters, including encounters with the elderly, the chronically ill, teens, mothers, infants, and children. More than 900 patients were served; 35 percent were Native American, and 4 percent were Hispanic. Approximately 40 percent of clients have private or public health insurance, 50 percent were Medicaid-eligible, and 10 percent were elderly persons

covered by Medicare. In addition, about 250 individuals received WIC assistance, about 250 received help from a public health nurse, and about 220 received mental health care.

Today, the clinic is equipped to stabilize heart attack victims prior to emergency transport and to address a wide range of minor emergencies. Once the new facility is constructed, the program will offer x-ray services. Doppler equipment will be acquired to be used to detect fetal heartbeat. Telemedicine equipment will be used in the new facility to provide emergency consultation with larger medical facilities and for mental health consultations, psychiatric evaluations, and staff training and development.

The program became the local leader in community education efforts. As such, the health center personnel continue to be actively involved in community health projects with the public school. The clinic cosponsored the annual Ashland Community Health Fair, where it provided low-cost health assessments and distributed health education materials. Medical providers and public health nurses taught classes on hygiene and puberty to local schoolchildren and coordinated health screenings for preschool and kindergarten children. The program also provided inservice programs for teachers, staff, and members of the community on HIV prevention and education, epilepsy, first aid, CPR (cardiopulmonary resuscitation), prevention of the spread of blood-borne pathogens, youth resiliency, and fetal alcohol syndrome education. Annual surveys conducted at the health fair indicated that residents were satisfied with both the range of services provided and the quality of care received.

Potential for Replication

This model, which is built on using health care providers from neighboring communities, can benefit any rural community wanting to increase access to care where making a long-term commitment to hiring a full-time provider is not a viable option.

After the Grant

In spite of its success in meeting the needs of an isolated, rural population, the Ashland Community Health Center has had difficulty securing funding to continue the project. The board is considering moving management of the clinic under the umbrella of a large medical facility, but project staff members remain optimistic that the program will be able to maintain its autonomy and grassroots persona. Project staff members are working with Eastern Montana Resource Conservation and Development to get advice on writing other grant proposals. They also remain in regular contact with the Montana Office of Rural Health, which is a valuable resource for potential funding opportunities.

Meanwhile, the health care board has developed a business plan, achieved 501(c)(3) status, and been recognized as a federally designated rural health clinic—the very first in the county and all of southeastern Montana.

NORTH CAROLINA

RURAL HEALTH SERVICES OUTREACH GRANT PROGRAM

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Population Served

Rural residents of western North Carolina are generally poor but proud people who have settled in the hollows and mountainsides of the rugged Blue Ridge Mountains. Accessing basic health care presents a formidable challenge, so recruiting physicians, primary care doctors, nurse practitioners, and physician assistants remains an urgent priority for this underserved region.

The Rural Outreach Program served 16 rural counties in the southern Appalachian region of western North Carolina. The primary goal of this program was to improve access to health care by recruiting and retaining primary care providers to set up practice in underserved areas and to increase the ability of local communities to address their unique health care problems.

The Rural Primary Care Support Network was a consortium that afforded primary care physicians and hospitals an opportunity to work together to help solve the health care needs of the region. Together, network members addressed various issues to strengthen the ability of communities to compete effectively with urban practice settings for primary care physicians. The network consisted of five rural hospitals, one urban hospital, six rural practices, and the Mountain Area Health Education Center (MAHEC). The network recruited physicians, nurse practitioners, and physician assistants; provided rural-specific medical training; promoted communication and continuing education among isolated rural hospitals and providers through an interactive video network; and enhanced the ability of communities to understand and address the health care needs of the community. The grantee, Margaret R. Pardee Memorial Hospital, provides fiscal oversight, whereas MAHEC provides overall program management and coordination. Evaluations are conducted by MAHEC Community Health Resource Services, and the Regional Outreach Work Group serves as an advisory board to the consortium.

Innovative Solutions to Problems

The program sponsored as many as three annual Rural Fellowships—1-year training programs designed to prepare physicians for rural practice. Fellows were placed in rural clinics with the hope that they will continue to serve the community on completion of the training. During the year, fellows spent

38 weeks in rural clinical training plus an additional 6 weeks of *locum tenens*, traveling to other clinics in the region to substitute for busy physicians who needed a break. The project also supported the Western North Carolina Practice Opportunity Fair, which matched health care providers looking for jobs with practices and communities in western North Carolina that have openings. The Western North Carolina Primary Care Physician Database kept track of how many providers came to but left the area, identified communities with high staff turnover rates, and was a valuable resource in developing provider recruitment and retention strategies.

The program also supported a range of training and technical assistance opportunities, which are coordinated by MAHEC Community Health Resource Services. These efforts were designed to prepare communities for building effective coalitions, conducting needs assessments, and developing and implementing action plans. Coalition membership typically included a mix of local residents and health care providers.

Results

In total, the four rural fellows who participated in the program and MAHEC faculty physicians conducted more than 8,200 patient visits in communities whose needs might have gone unmet because of health care professional shortages and absences. For example, the program provided health care professionals for several small rural practices where patients would have had to travel to a distant emergency room for medical care because of their doctor's absence. It also benefited an HIV wellness center whose patients would not have had any medical care while their practitioner was away. All four physicians who participated have stayed in western North Carolina. In addition, 20 physicians and 1 physician assistant are now practicing in western North Carolina as a result of contacts made at Western North Carolina Practice Opportunity Fairs and other outreach efforts.

The local coalitions also yielded tremendous success. One coalition in the region implemented health promotion and disease prevention strategies in its county focusing on nutrition, fitness, and mental health. In another county, the fire department (a coalition member) organized a flu shot campaign that reached 450 residents. In addition, by the end of 1999, all 15 of the rural hospitals in western North Carolina were connected to the interactive video network.

Over the course of the grant period, MAHEC Community Health Resource Services successfully expanded its services to nine different counties, assisting these counties in establishing sustainable community health coalitions. These coalitions have secured ongoing funding and are actively addressing their own

unique health priorities. MAHEC Community Health Resource Services is now a recognized regional resource for technical assistance and training to form and sustain community health improvement efforts.

One of the most important lessons learned as a result of the project was that prepackaged community coalition training modules generally do not work. Coalitions developed at their own pace and had their particular resource and training needs. Each county requires customized and adapted materials that fit its specific training needs, health priorities, and development tasks. In addition, the project learned that local residents should be actively involved in the coalition development process to help establish trust and to ensure a community-driven health planning process. Instead of acting as experts, staff members quickly learned the value of serving as facilitators, coaches, and conduits for sharing experiences and information.

Potential for Replication

This project is particularly useful for rural areas with Area Health Education Centers, universities, and other community agencies that have the capability to organize a network of community organizations, doctors, and hospitals. It also serves as a promising model for others seeking to design education programs for physicians in rural practice, provide relief for rural doctors, and support technical assistance and consultation to community coalitions.

After the Grant

The Rural Primary Care Support Network will continue to identify and prioritize public health challenges that require communitywide and regionwide collaboration. For example, the network is considering a collaborative, multicounty system to improve asthma morbidity.

The program is seeking alternative funding for the Rural Fellows Program so that it can continue to benefit the western North Carolina region. In addition, MAHEC Community Health Resource Services will continue to provide technical assistance and consultation to community coalitions throughout the region, sponsor the Western North Carolina Practice Opportunity Fair, and operate the Western North Carolina Primary Care Physician Database.

OKLAHOMA

DOCS RURAL OUTREACH PROGRAM

MIAMI, OKLAHOMA

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Population Served

The service area for the Delaware, Ottawa, Craig Seniors (DOCS) Services program is a rural, tricounty area in northeast Oklahoma. The region, which is split geographically by Grand Lake, has over the years acquired a national reputation as an ideal location for retired individuals—largely because of the rural setting, access to activities, and the low cost of living.

Over the past few decades, the region has seen a dramatic increase in population growth, mostly of retired individuals older than age 65. Many of these seniors retired here as couples 20 years ago, and although many may be able to afford health care and related support services, the rural setting makes it difficult to access such services. The area also is home to a large Native American population and has experienced an increase in the number of low-income elderly individuals.

Services Provided

The DOCS Rural Outreach Program was created so that local elderly individuals could receive in-home assistance with bathing, housekeeping, and other support services. However, because of the widespread demand for these services and the difficulty in obtaining Medicare reimbursement for such care, the project focused on creating a network that could meet this demand by making the most of existing local resources. The program was also designed to provide training for housekeeping staff so that they could serve as certified nurse aids and to expand outreach efforts to the elderly and linkages among existing programs serving the elderly.

The network consortium was composed of DOCS Services, an Older Americans Act provider; Pelivan Rural Transit, a member of the Oklahoma Transit Authority; the Miami Housing Authority; the Delaware, Ottawa, and Craig County Health Departments; the Northeast Area Vo-Tech School; and the Inter-Tribal Council, a consortium of organizations serving the region's tribal population. Together, consortium agencies provided a range of services, including:

- In-home custodial bathing and grooming care
- Nutrition education and health screenings
- Meals
- Transportation for low-income, rural individuals

- Training so that DOCS Services in-home staff members could become certified nurse aids
- Oversight of in-home workers providing personal care services.

Innovative Solutions to Problems

The most significant barrier to service delivery was access. Reimbursing staff members for travel expenses often cost more than what was originally budgeted, and transportation was a serious problem for the area's most isolated and frail clients. The participation of the Pelivan Rural Transit program was critical in addressing this problem. It provided a cost-effective means for delivering meals and for ensuring that clients kept medical appointments.

Another major challenge was the Oklahoma Medicaid Waiver program—called Advantage. The program was generally not equipped to meet the needs of elderly Oklahomans with extensive in-home care needs. This service gap pressured the consortium to develop a more reliable and cost-effective program to address the unique home care needs of elderly Oklahomans. It also underscored the need to determine a reliable and workable capitation rate for the delivery of in-home personal care services and to educate State policymakers about ways to finance these services in a more cost-effective and comprehensive way.

Results

As a result of the grant, the program provided more than 11,200 units of in-home custodial and personal care services. In addition, eight staff members were trained and certified as nurse aids, and more than 600 rural residents were linked to the services available through the network. In addition, 181 clients received more than 2,300 meals, 13 received reliable transportation services, and 226 received screening and education services. The typical client served by the program was over age 75, was in frail condition, was female, and had an income 50 percent below the median for this area.

By working together, consortium members demonstrated a cost-effective alternative for long-term care. For example, services provided would have cost more than $720,000 had they been paid for through Medicare reimbursement; however, the program provided these services at roughly one-third the cost—a fact that will be useful when grassroots organizations attempt to educate State policymakers about more effective ways to meet the personal care needs of elderly Oklahomans.

The most important lesson learned was that agencies with different funding sources and unique priorities can work together effectively and achieve common goals. Although grassroots organizations may not be able to directly control State policies, they can participate in the policymaking process by educating policymakers about the needs of seniors and how to best meet those needs.

Potential for Replication

This model can be easily replicated in other communities, especially if local service providers work together as a local network and are governed by a local body, committed to doing what is best for the local population, and funded based on locally determined capitation rates. The biggest challenge, however, will most likely be overcoming "turfism" among local service providers.

After the Grant

DOCS Services, the Miami Housing Authority, the Integris Hospital Group, the Inter-Tribal Council, and Ottawa, Delaware, and Craig Health Departments agreed to form a rural network of providers whose mission was to increase the availability of cost-effective services throughout the region and to effect positive changes in State policy. Throughout the grant period, DOCS Services reached out to county, city, and other agencies as sources of additional funding to expand in-home custodial services as the demand increased.

PENNSYLVANIA

CLINTON COUNTY COMMUNITY HEALTH OUTREACH PROJECT LOCK HAVEN HOSPITAL AND EXTENDED CARE

LOCK HAVEN, PENNSYLVANIA

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Population Served

Clinton County, Pennsylvania, lies in northern Appalachia and covers about 900 square miles, most of which is forest or agricultural land. Its 37,000 residents, who include a large and growing Amish population, live in 27 different townships or boroughs nestled in valleys along the Susquehanna River, with 11,000 people making their homes in Lock Haven. The vast majority of residents are white, and the region as a whole suffers from severe economic depression and low incomes. The county has been designated as both Medically Underserved and a Health Professions Shortage Area because the county is divided into distinct regions and communities that are typically socially and geographically isolated. Most health care services, including the hospital, are located in Lock Haven.

Clinton County's morbidity and mortality rates from chronic disease exceed statewide rates. Although some forms of cancer, heart disease, and diabetes can be prevented or treated effectively through early detection and basic lifestyle changes, only limited prevention and health promotion services were available at the time of grant award. Most of those services were available only to those who were able to travel to Lock Haven. Unfortunately, many of the county's most isolated residents were unable to do so.

Services Provided

In 1996 Lock Haven Hospital forged the development of the Community Health Consortium. Members of the consortium included Lock Haven Hospital, the Lock Haven University Physician Assistant in Rural Primary Care Program, the Pennsylvania Department of Health, the Pennsylvania State University Cooperative Extension Service, and local volunteer fire companies. The program established a series of regularly scheduled screenings for hypertension, cholesterol, diabetes, colon and prostate cancer, and other chronic conditions. These screenings were held in local firehouses and the social centers of many communities throughout the region and were conducted by physician assistant students. The project also sponsored classes on smoking cessation, exercise, heart care, diet, nutrition, and other healthy behaviors taught by physician assistant students; outreach workers; extension agents; firefighters; and other members of the community, including doctors, lawyers, and dentists. Screenings

and classes were open to all county residents, with an emphasis on recruiting rural residents of all age groups. Because so many residents are unable to travel to Lock Haven to receive screenings or to attend classes, local fire stations provided an effective means to participate in these health promotion activities.

Innovative Solutions to Problems

From the outset of the program, it was clear that each community had different interests and needs. To ensure that the program was responsive to the diversity of the target communities, project staff members conducted ongoing and continuous needs assessments. Outreach workers were sent into the communities to survey people in their homes, in supermarkets, and even on the streets so that they could find out what classes or topics residents wanted to have presented in their community. Ultimately, class topics ranged from bicycle safety to eye disease among the elderly to first aid.

The program also sponsored a Farm Safety Workshop for farmers, firefighters, and emergency medical technicians. Two local farm equipment dealers provided tractors, balers, feed mixers, and other equipment and, in collaboration with local extension agents, described the kinds of farming accidents and injuries that can occur, how to prevent injuries, and instructions for stopping the equipment properly and extricating someone who becomes caught or entangled.

Another innovative approach to health education and promotion of healthier behaviors was the creation of Walking Clubs. To encourage exercise among local residents, program staff members provided classes on the health benefits of walking, safety, and proper shoe and foot care. Eventually, competitive walking clubs were established at each fire station. Members kept track of the miles they walked, and the firehouse that accumulated the most miles among its members was honored by a banquet, featuring low-fat and heart-healthy foods. The Walking Clubs have become so popular that several employers in the county sponsor teams that participate in the competition.

Throughout the project, however, staff members struggled with the challenge of involving Amish residents in health education and health promotion activities. Two areas of the county, Sugar Valley and Lamar, have a high concentration of Amish residents, and although services were open to everyone, participation by Amish individuals varied. As a result of a meeting between the Outreach Program Director and the Amish Bishop in Sugar Valley, many Amish families attended outreach activities at the firehouse, prompting the need to install a hitching post for their horses. Program staff members were also invited to

provide first aid and safety training to several Amish-owned businesses. However, significantly fewer Amish residents in Lamar have elected to participate in health education and outreach programs.

Each member of the consortium contributed to the project by providing space, personnel, expertise, and resources. The hospital offered community-based prevention services, and the physician assistant students who conducted the screenings and seminars—all of whom are being prepared to serve in rural areas—received valuable training and experience. The extension service and fire stations benefited from their participation in the project by increasing their visibility in the community beyond the traditional roles of agriculture and fire suppression.

Results

During 1997 the project conducted 138 screenings at eight fire stations. In 1998 it provided 324 screening events and 374 seminars at 12 fire stations and at a variety of community events, such as parades, craft shows, barbecues, county fairs, blood drives, and the annual health fair. The total number of people who participated in at least one event was 5,021, but the average annual attendance for all events averaged 7,000. Most of those who received screenings or participated in the seminars were women and people over age 50.

The project played an important role in identifying serious, undiagnosed health conditions and in providing referrals to followup treatment. For example, more than half the men tested at one of the Hunter Health Screenings had elevated cholesterol levels, and one-quarter had very elevated levels. As a direct result of the project-sponsored health screenings, more than 100 people with previously undetected conditions, such as diabetes, hypertension, or prostate cancer, were identified and referred to medical care.

The continued participation in the health screenings and the walking club are indications of the participants' increased awareness and active interest in their personal health.

One of the most exciting results of the project was that the physician assistant program curriculum was revised to include student participation in outreach activities. This feature of the program has received national recognition.

Potential for Replication

This project can be readily duplicated in both rural and urban areas. The use of community and neighborhood organizations as the point of contact in the community has been very effective. In this case fire stations were used, but other settings, such as churches, synagogues, community centers, schools, and other institutions, can be used to offer community health screenings and seminars.

For this project, the involvement of the Lock Haven University Physician Assistant in Rural Primary Care Program was critical to the service strategy because the students conducted the screenings and seminars. Although not every community has a university, comparable programs may exist within the State or region, and existing providers may be willing to contribute time or resources.

After the Grant

Both the hospital and the university have committed to providing ongoing support for the program. The project also received a grant from the Pennsylvania Department of Health to increase blood pressure and stroke awareness. Another grant from a tobacco use prevention coalition is being used to create a tobacco use prevention campaign for youth. The program continues to seek additional funding for similar, focused health promotion programs.

SOUTH CAROLINA

YEMASSEE OUTREACH NETWORK
LOW COUNTRY HEALTH CARE SYSTEMS, INC.

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Population Served

Yemassee is a small town in the historic Low Country of South Carolina. Located in lower Hampton County, which is known for its deep forests, swamps, ponds, and the annual Yemassee Shrimp Festival, it has abundant wildlife conducive to bird and alligator watching as well as ample game for hunting and fishing. Yemassee and the surrounding rural communities also contain a large number of farms, antebellum plantations, and historic churches.

The people who live in and around Yemassee suffer from rampant poverty. Many are ethnic minorities, elderly, or both. The town has a limited economic infrastructure, and access to health care and social services is extremely limited. Combined, these factors contribute to the town's high rates of infant mortality, heart disease, cancer, and stroke.

Services Provided

The Yemassee Outreach Network (YON) was created to provide preventive and primary health care services to Yemassee residents and to those who live in surrounding Hampton, Beaufort, Colleton, and Jasper Counties. The consortium includes the Low Country Area Health Education Center, which is the project grantee; the Harrison Peebles Health Care Center (which is located in Hampton, 21 miles away, and became part of the Low Country Area Health Education Center in the second year of the grant), the town of Yemassee, and the Medical University of South Carolina (MUSC). Although the grantee organization provides overall administrative oversight and clinical support, MUSC provides evaluation support and provides nurse practitioners and pharmacy students, who work on training rotations. Together, the consortium brings a critical mass of human resources to meet the daunting health care needs of this rural community.

The focal point of the project is an outreach clinic next door to Yemassee's city hall. Staffed by a full-time nurse practitioner, a part-time physician, and a receptionist, the clinic provides preventive and primary medical care to a predominantly female and African-American clientele. The opening of the clinic attracted the district's Congressman, major State and local officials, and many community residents. The Harrison Peebles Health Care Center provides additional physician staff, clinical support, and recordkeeping and billing services.

Since the beginning the project, the YON Advisory Board has played a major role in project implementation. Composed of community residents, including the Mayor of Yemassee, the advisory board shaped the clinic program, supported health promotion training sessions in local schools and churches, and helped the clinic gain acceptance throughout the community. The clinic also enjoys the active support of town officials, who have promoted the clinic widely and have arranged for its address and hours of operation to be printed on city water bills.

Innovative Solutions to Problems

Before the grant award, the shortest distance that local residents had to travel to fill their prescriptions was 18 miles. Changes in the State's pharmacy dispensing law prevented the clinic from opening its own pharmacy, even though the facility had been renovated to provide prescriptions on-site. To ensure that people had easier access to their prescriptions, the city provided a courier service to pick up prescriptions (except narcotics) at a distant pharmacy and to deliver them to patients' homes.

One of the main reasons that the program quickly gained the confidence of the community was its ability to recruit clinical providers. By participating in the South Carolina Rural Interdisciplinary Program of Training, health professions students can receive their clinical training at the Yemassee clinic in the future.

Results

YON successfully achieved its four goals: (1) improve access to primary and preventive services throughout the area, (2) expand the role of MUSC as a resource support center, (3) improve the health status of the community, and (4) conduct health care-specific educational activities. In all, the program has served more than 650 residents.

The most significant lesson learned from the project's qualitative evaluation was that the success of a rural health services delivery project hinges on the program's ability to engage the community as a full and meaningful partner. For example, once community members understood that Federal funding for the program would end, they became committed to ensuring the survival of the clinic. In addition, having members of the community serving on the advisory committee was important to ensure that the program was truly responsive to the needs of the community, thereby enabling the project to achieve and maintain broad-based community support.

Potential for Replication

The Yemassee Outreach Network is well suited for application in other rural areas. Using a nurse practitioner or part-time physician seems to be a successful approach for small, rural, economically disadvantaged communities. When coupled with the resources brought to the project by an academic health institution, this approach provided an outstanding training opportunity for health professions students, which increased access to care for a poor, rural community and successfully addressed the health care needs of rural residents. However, it is critically important to involve the community in organizing such programs and in gaining the support of local residents at an early stage.

After the Grant

When Federal funding ended, the clinic did not have the sufficient volume of patients to keep the doors open 5 days a week. As a result, clinic operations were scaled back to 2 days and 1 afternoon per week. The town of Yemassee continues to provide pharmacy courier services for clinic patients and is aggressively marketing the clinic's services so that the utilization of services will increase and the clinic can continue operations, even if on a limited schedule. The Low Country Area Health Education Center and MUSC will continue to provide training opportunities for health professions students, and the University of South Carolina School of Public Health is exploring future grant support to ensure the clinic's continuation and growth.

Population Served

The Rural Dakotas are a sparsely populated region—6.4 people per square mile—that serves as home to 93,000 people who live in 11 rural counties in South Dakota and 1 county in North Dakota. More than 20 percent of residents are older than 65, and about 20 percent live below poverty level. (The level is 6 percent higher in Roberts County, South Dakota, where there is a very large Native American population.) Rural residents in the region have limited access to health care services, and the few providers who practice there have virtually no opportunities to improve their skills and further their education.

Services Provided

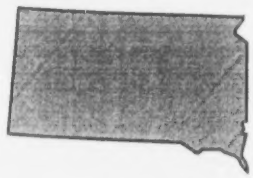
The Dakota Health Network Project used emerging technologies—telehealth and telemedicine—to bring primary health care, specialty medical consultations, and health education programs to rural communities. These technologies were also used to provide continuing education and training opportunities for local health care providers. Specifically, the goals of the project were to recruit and retain health care providers, ease the geographic barriers to primary health care services, make specialty care more accessible to rural residents in their own communities, and improve the availability and efficiency of emergency medical services.

The consortium included 11 small rural hospitals, 2 rural clinics, a school, and the hub site at Avera St. Luke's in Aberdeen. Although the overall project was managed by a telehealth coordinator, consortium members selected site coordinators who managed the day-to-day activities of their network site.

Innovative Solutions to Problems

As a result of the Dakota Health Network Project, area physicians and professional health care staff members were able to receive continuing education credits without leaving their homes or patients. Recently, the program expanded its efforts to include continuing education opportunities for radiology technicians at outreach locations. The network also offered monthly health care forums, led by specialty physicians, that were available to all network sites. Also available were a Grand Rounds program, a cardiovascular conference program, and a tumor conference initiative—all of which were enthusiastically received. In addition,

SOUTH DAKOTA



DAKOTA HEALTH NETWORK PROJECT AVERA ST. LUKE'S

ABERDEEN, SOUTH DAKOTA

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the network continues to make its community wellness programs available to a regional distance-learning network composed of eight schools. Although there are numerous technological challenges associated with this task, the process is moving forward.

One of the biggest challenges encountered during implementation of the network was the lack of available ISDN service. However, Network staff members worked closely with local telecommunication companies to educate them about the importance of having the service available to the network sites and to support their efforts to make the service available.

Another serious challenge the network faced was the unavailability of an advocate for telemedicine—either on behalf of the network as a whole or the network sites. Program staff members made numerous presentations to local specialists to engage them in the process; however, most specialists rarely took the iniative to participate.

Results

The Rural Health Outreach Grant enabled the Dakota Health Network Project to demonstrate how interactive videoconferencing could be successfully used to provide distance education for providers and to promote wellness among local residents. Throughout the project, 724 individuals participated in 72 medical education programs, 156 people attended 17 community health programs, and 31 specialist physicians participated in 12 telemedicine consultations. In all, the program benefited nearly 1,500 rural residents, most of whom were adults between ages 20 and 64.

Today, the Network offers myriad education and community wellness programs for rural physicians, midlevel providers, and members of the community. Telemedicine services have been limited, but the project has ambitious plans for making telemedicine a more integral part of health service delivery in the future. The project was also successful in improving access to health care services for rural residents and in reducing the isolation of rural providers. The program provided wellness programs, patient education, and continuing medical education opportunities that had never before been available to rural areas.

Although the project may not have been successful in marketing telemedicine to providers and in obtaining their support in providing telemedicine consultations, the project achieved a great deal of success in demonstrating that the new technology *can* work in rural areas.

Potential for Replication

This model would be particularly useful for any community or organization seeking to enhance distance education opportunities for isolated health care providers. For communities interested in expanding their services to include telemedicine technologies, it is important to have a vocal and respected advocate who can educate providers about the technology and about the enormous benefits it holds for them and their patients.

However, before such a program is launched, project planners need to be aware that significant upgrades in computers and other equipment may be necessary to ensure that the technology works effectively. They also need to be aware that the latest technologies are always changing, and staying abreast of these rapid advances is a formidable challenge

After the Grant

Avera St. Luke's has already committed to an aggressive remodeling project that will significantly improve the interactive studio. This has been identified as a top priority for the facility, which has demonstrated strong and unwavering support for the project.

TENNESSEE

LOUDON SCHOOL HEALTH CONSORTIUM
LENOIR CITY SCHOOLS

LENOIR CITY, TENNESSEE

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Population Served

Loudon County, Tennessee, is a small, rural county that had a per capita income of $12,006 in 1990—a figure well below State and national levels. In 1995, 19 percent of the population was covered by TennCare, the State's Medicaid managed care program, and nearly 36,000 Loudon County residents were receiving health care from only 11 primary care physicians.

In addition to rampant poverty and a lack of health care providers, access to health care was severely limited by the county's narrow and winding roads, the distance from health services, and a lack of public transportation.

After an extensive review of community data and input from the community, the Loudon County Community Health Improvement Council, which comprises community citizens, health professionals, and social service providers, identified adolescent health care services as a top priority for the county. Adolescence is indeed a time of experimentation that can lead to risky behaviors and negative consequences. The council believed that the community should provide adolescents with confidential and accessible education and health services that focus o. nental health, substance abuse, and sexuality.

Services Provided

To address these needs, a school-based health center was created to bridge the gap between health education and services. The project targeted 1,300 high school and middle school students, many of whom lived in remote areas of the county, as well as school faculty and staff. The primary goal of the program was to improve access to primary care and mental health services and to help students be responsible decisionmakers about their health.

The Loudon School Health Consortium is made up of Lenoir City Schools, Fort Sanders Loudon Medical Center, and Peninsula Behavioral Health. The school provided space for a school-based health center and supervision for staff. The Fort Sanders Loudon Medical Center provided technical assistance and support, cultivated relationships between the health center and the health care community, and provided $6,000 in in-kind laboratory services to the health center over the life of the project. Peninsula Behavioral Health provided a case manager at the school-based health center who served as a source of support and referrals to

community resources. To receive primary care or mental health services, students had to be enrolled in the health center and have parental permission. However, all students had access to the traditional school nurse services.

The program's school nurse provided medications, first aid, screenings, and immunizations. A nurse practitioner provided health assessments, sports exams, diagnosis and treatment of acute illness and injuries, guidance in managing chronic conditions, and referrals for additional care. Mental health services, such as individual and family counseling; crisis management; support and information groups; and assessments, referrals, and case management were available to students and school staff. Finally, the programs sponsored a range of health education programs on tobacco use, substance abuse, stress, conflict management, nutrition, weight control, relationship issues, and self-esteem.

Innovative Solutions to Problems

Many students receive services at the health center because of the direct involvement of teachers and parents. When it became evident that a student needed services, teachers and parents referred the student to a core team made up of the principal, guidance counselor, and mental health staff. The core team, which met weekly, assessesed each student's needs and recommended an individualized service plan. Services provided included mental health counseling, faculty mentoring, parenting classes, alternative school placement, support groups, and health education classes. The team monitored each student's progress and altered the service plan as needed.

One of the most unique features of the program is that health center staff members work with school faculty to identify and train high school psychology students for a peer counseling program. Under the supervision of the health center's social worker, the peer counselors provided assistance to their fellow students.

Ironically, not everyone in the community supported the school-based health center concept. Some local religious groups were opposed to the center because they were concerned that the health center would provide reproductive health services without parental knowledge or consent—even though the program was designed to provide only pregnancy testing, sexually transmitted disease testing, education, and referrals. As a result, one of the consortium's original partners, the county school board, withdrew from the consortium just a few weeks before the program was scheduled to begin, and a local vocational high school was dropped from participation in the health center program. To fill the void in the consortium, Peninsula Behavioral Health joined the consortium, and Lenoir City Middle School was substituted for the vocational school.

Results

As a result of this project, 70 percent of area students enrolled in the school-based health center, and nearly 15,000 students and school staff members visited the health center. Nearly 270 students received mental health services, and the health education classes resulted in more than 8,700 student contacts.

The health education classes resulted in several positive health and prevention outcomes. For example, 9 percent of students surveyed reported that they had either stopped smoking or decided not to start smoking as a result of the smoking cessation class, and 11 percent reported that they were exercising more, with 8 percent indicating that they had lost weight. About 34 percent reported being able to control their own stress, anger, and conflicts.

The program also provided peer counseling training to 16 high school students and sponsored a faculty mentor program. In addition, for the 1999-2000 school year, the high school will launch a health occupations course to provide students with job skills for health-related jobs.

Since opening its doors in August 1997, the school-based health center has seen a substantial increase in use by students, parents, and school staff. Many referrals and requests for health center services came from local health care providers and students' family members. Parents and teachers appreciate the convenience of being able to access services on-site because students miss less class time and parents do not have to miss work.

The consortium functioned as originally planned and played a major role in the project's success. However, the project was unable to pursue third-party reimbursement for health center services because the local and State-managed care environment was not receptive to contracting with school-based health centers. It is unlikely that this will change any time soon.

> "THE MOST SIGNIFICANT LESSON LEARNED IS THE IMPORTANCE OF ADEQUATE UP-FRONT PLANNING. EXPERIENCED SCHOOL PERSONNEL AND HEALTH CARE PROVIDERS SHOULD BE INVOLVED WITH THE PLANNING. ADEQUATE TIME SHOULD BE GIVEN TO THE PLANNING PHASE, INCLUDING VISITS TO OTHER, SIMILAR PROJECT SITES AND MEETINGS WITH PARENTS AND OTHER MEMBERS OF THE COMMUNITY. IN ADDITION, PLANS FOR EVALUATION SHOULD BE INCLUDED FROM THE BEGINNING OF THE PROJECT."
>
> —LOUDON SCHOOL HEALTH CONSORTIUM FINAL PROJECT REPORT

Potential for Replication

Similar projects would work well in other rural settings. However, the project must be individualized to reflect the needs and values of each community and the characteristics of the school system. A school-based health center can be an important asset to a community, but there must be an understanding of how the health center will fit into the community's existing health care system. In addition, personnel and community members must accept that a school is an appropriate place to provide health services to students.

Communities that consider starting a school-based health center may face opposition from conservative groups that oppose reproductive health care, student confidentiality, or any government-sponsored health program. There may also be opposition from local health care providers who view the health center as unnecessary or as competition or from school administrators and teachers who do not believe that health care services should be provided on school grounds or during class time.

After the Grant

The consortium continues to seek local, State, and Federal funding sources for the school-based health center. Because the State of Tennessee has expressed increasing interest in comprehensive school health programs, there may be opportunities for State funding in the future.

TEXAS

PROJECT SCOUT
SHACKELFORD COUNTY COMMUNITY RESOURCE CENTER

ALBANY, TEXAS

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Population Served

Shackelford County, located in north-central Texas, is a federally designated Medically Underserved and Health Professions Shortage Area. Although the county consists of 914 square miles and is home to a population of nearly 3,500 individuals, there are no hospitals, physicians, or dentists, making access to basic health care extremely limited. The county had a hospital and two physicians; however, the hospital closed in 1997, and the physicians moved away. One family nurse practitioner who commutes from another community is available from 8:30 a.m. to 4:30 p.m. at the First Med Clinic in Albany, which is part of Shackelford County. There are no evening or weekend services.

Services Provided

Project SCOUT was created to provide basic health care; referrals to health, social, and human services; provider training; health promotion and disease prevention education; in-home parenting education; and prenatal care to expectant mothers or well-baby care to at-risk families with infants. The project was created using Hawaii's "Healthy Family" program as a model and was modified for implementation in a rural area. Whereas the Hawaii program screened and identified families while they were in the hospital, this approach was not possible because the county did not have a local hospital.

As a one-stop-shopping model of health care, Project SCOUT, located in the Shackelford County Community Resource Center, offers a broad range of health and social services within one building, making it significantly easier for clients to gain access to services and supports. Although not all the services in the building are directly funded by Project SCOUT, the program successfully collaborated with other health and social service agencies so that clients had access to myriad services. In fact, Project SCOUT gave clients access to the services of nearly 30 other local agencies and providers—many of which are colocated in one building.

To identify families that would qualify for services, the program sought out at-risk families using government and social service programs, such as the Women, Infants, and Children (WIC) program, Child Protective Services, the Food Stamp program, and

Medicaid as well as those identified by local health care providers. Soon after the program opened, referrals began pouring in—not only from local agencies but also from the community at large.

Innovative Solutions to Problems

One of the most important facets of Project SCOUT is its home visitation program. Seeing where families live enables family support workers to identify factors that need to be addressed to prevent future child abuse, neglect, or maltreatment. Family support workers also teach parents life skills, parenting skills, anger management, and other skills.

During the first year of the program, prenatal care was provided on-site at the WIC program offices. However, as health care budgets all over the State began to tighten, WIC was no longer able to provide the service. SCOUT staff members became aggressive in locating prenatal care services and in ensuring that expectant mothers had transportation to and from appointments. Ultimately, becoming involved with a family during the prenatal stage opened the door to meeting the needs of the whole family, with a strong emphasis being placed on helping each family locate a reliable and permanent source of health care.

Also, as the project unfolded, it quickly became clear that the original goal of reaching more than 70 families was unattainable because one full-time and one part-time case manager simply could not handle the caseload. Although the project was intended to focus on providing basic health care, it was nearly impossible to accomplish that objective because the families' needs for the basics—food, shelter, and clothing—were far more immediate. Once three full-time case workers were on the program, the project was able to establish an ongoing, one-on-one relationship between case workers and families to ensure that each family got the needed individualized attention.

Results

By the end of the Rural Health Outreach Demonstration Grant funding cycle, Project SCOUT was averaging approximately 1,837 client encounters per month. These included individuals who needed prenatal care, diabetes counseling, immunizations, parenting classes, referrals to food banks and clothing centers, breast cancer education, and dozens of other health and education services. Between October 1996 and July 1999, nearly 3,500 individuals had been referred to the clothing center, more than 900 to the food bank, more than 1,500 to WIC, and more than 1,100 to immunization services. In addition, the program recorded 132 units of service for the "Adopt-A-Buddy" program, which helped families with more than one child in school obtain expensive school supplies, and

720 young people participated in the Summer Day Camp Program, which provided anger management and decisionmaking education to at-risk fourth, fifth, and sixth graders.

One of the biggest reasons for the project's overall success was the knowledge of local resources extant within the project's consortium. Consortium members often cross-referred clients and provided guidance to Project SCOUT staff on additional health and social service programs throughout the county.

Potential for Replication

The basic idea of health promotion, disease prevention, early intervention, and one-on-one casework is an easily transferable concept. Any rural community with caring people can replicate this program. However, it is important to note that this program is located in a building that houses many agencies and programs that provide a vast array of resources. Other rural communities may find that, without such a resource, locating services and providing referrals can create major hurdles. Significantly more time will have to be devoted to providing transportation to and from appointments. Indeed, having services colocated saves both time and money that can be used for program improvements, educational materials, and staff training.

Another issue to be considered is finding adequately trained and experienced staff. It is difficult to locate professionals who have the skills and training necessary to provide intensive case management and health education, and it is even more difficult recruiting people from other areas to serve in a rural setting when opportunities in a larger metropolitan area are far more lucrative.

After the Grant

Project SCOUT continues to provide in-home visits, parenting skills training, mentoring with mothers, and family strength-building programs. The resource center will continue to educate local community members through media coverage and public presentations. Project SCOUT has already secured funding through a Community-Oriented Primary Care Grant, the Hogg Foundation, and the Texas Department of Health "Take Time for Kids" Initiative and continues to raise funds through foundations, State and Federal block grants, and other local fundraising activities.

VERMONT

VERMONT COALITION OF CLINICS FOR THE UNINSURED ADDISON COUNTY COMMUNITY ACTION GROUP, INC.

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Population Served

A 1993 survey by the Robert Wood Johnson Foundation revealed that 11 percent of Vermont residents, or 62,000 people, lacked health insurance. To address this need, five free clinics throughout the State met to compare notes on how they were meeting the health care needs of uninsured people who were below 200 percent of the Federal poverty level. As a result of the meeting, the clinics formed a loose consortium, the Vermont Coalition of Clinics for the Uninsured (VCCU). After receiving a Rural Health Outreach Grant, the coalition expanded to include four additional free clinics and one free dental clinic. The typical VCCU client is 37 years old, is a white female, is uninsured, is employed either part time or full time, has a high school education, and has an income below 200 percent of the Federal poverty level.

Services Provided

The free clinics provide a range of primary and preventive health care services, including women's health services; physical therapy; nutrition counseling; mental health services; anonymous HIV testing and counseling; and referrals to specialized care, laboratory services, and x-rays. Most of the clinics in the consortium provide vouchers for free laboratory services, x-ray services, and ancillary testing; one clinic provides free dental care 1 evening per week thanks to area dentists who volunteer their services. All patients receive assistance in enrolling in Medicaid, Medicaid extension programs, and a variety of social services when eligible.

Innovative Solutions to Problems

Each VCCU member collects a common set of data on patients and patient visits, referrals, volunteer hours, responsibilities, and clinic attendance as well as other useful information. The consortium also devoted considerable time and effort to establish a long list of dedicated volunteers and a solid referral base. In fact, over the course of the project, the coalition's clinics established a strong working relationship with physicians, specialists, and hospitals throughout the State.

Initially, some of the clinics had difficulty with the consortium's financial reporting and recordkeeping procedures. To solve this problem, the VCCU coordinating office provided technical assistance to the clinics needing training, and as a result, clinic managers successfully integrated these practices into their management policies.

Results

In the first year of the grant, the clinics observed a dramatic increase in the number of patients—160 percent. In the second year, the number of patients increased by nearly 50 percent, and another increase of approximately 36 percent was achieved in year 3. Between 17.5 and 22.0 percent of uninsured adults in the entire State of Vermont have been served by one of the nine VCCU clinics at some point during the grant cycle, and currently, VCCU serves 80 percent of Vermont's counties. In all, the program served 10,700 patients, who accessed services 18,600 times.

The value of the free clinics—in both human and economic terms—cannot be overstated. As demonstrated by a survey, 44 percent of clients said they would not have sought care if their local clinic had not been available, and 25 percent stated that they would have had to seek care in an emergency room. An astounding 80 percent of those surveyed also indicated that they had delayed seeking care because they were unable to pay for services received.

The consortium clinics and their leaders are working together to influence the State's health policy structure and to advocate on behalf of Vermont's uninsured residents while at the same time responding to local health care needs. For example, project data showed that depression was among the most common diagnoses made of clients, with anxiety disorders following closely behind. These findings resulted in the establishment of specialized mental health clinics. In addition, the State legislature requested that VCCU testify in hearings on health issues affecting the working poor.

The consortium unfortunately was not able to conquer every challenge it faced. Free clinics are not always efficient or cost-effective. The reality is that clinics rely on the generosity of the communities, and they often are open only during evening hours—a block of time that for volunteers often follows a long and difficult workday.

As for the clients, many clinic patients have complicated health care problems, such as diabetes or hypertension, that have been neglected for a long time; although some clients do not comply with their treatment regimen, the clinics note that many clients respond in an unusually positive way to a broad range of services, which may include nutrition counseling, physical therapy, and

psychological counseling, in addition to the primary health care offered. Obtaining access to specialty care can be difficult, although many clinics have developed funds to cover the expensive testing that is part of that care. Many rural residents lack access to transportation, and keeping in contact with clients is difficult if the client does not have a telephone.

Potential for Replication

VCCU serves as a model for any rural community seeking to increase access to health care, reduce the number of uninsured residents, ensure provider continuity through followup care, develop a solid volunteer base, and implement uniform reporting and recordkeeping processes across multiple sites. One of the most important lessons learned through this project is that part-time case managers and volunteers, including volunteer providers, can play an important role in a successful free clinic.

After the Grant

VCCU was granted 501(c)(3) status in late 1998, and the consortium has successfully secured ongoing funding to continue providing services to people who would otherwise lack access to care.

VERMONT

WOMEN AND MANAGED CARE INITIATIVE GOVERNOR'S COMMISSION ON WOMEN

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Population Served

Like the Nation as a whole, Vermont has a health care delivery system that has undergone rapid and momentous change because of managed care. As of July 1998, 33 percent of the State's insured population was enrolled in managed care plans. As the number of Vermont residents enrolled in managed care programs has increased in recent years, so has the need for educating consumers on how to navigate managed care systems effectively. This is especially true for women, who usually make the majority of health care decisions for themselves and for their families. Individuals who do not have access to information about how managed care works may experience difficulty getting the care they need, and they may incur additional health care expenses when they do not observe the rules and restrictions typically associated with managed health care systems.

Services Provided

The Women and Managed Care Initiative (WMCI) was created to help women throughout Vermont better understand managed care and the most effective ways to use it. The education program targeted Vermont's low- and middle-income rural women living in the 13 counties meeting the Federal definition of "rural."

The WMCI network is composed of seven organizations, including the Governor's Commission on Women, a statewide low-income advocacy organization, a statewide advocacy organization for people with disabilities, the State's Women, Infants, and Children program, two adult literacy organizations, and the statewide health insurance counseling program that serves older residents. Together, WMCI members provided advice on how to conduct focus groups, the recruitment of focus group participants, the needs of constituents served by their individual organizations, the development of educational materials, and participation in the development of a detailed plan for distributing and publicizing the Women and Managed Care Initiative.

Innovative Solutions to Problems

WMCI held a series of focus groups to gather information from members of the target audience on both *what* they need to know about managed care and *how* they would prefer to learn about the subject.

When it came time to produce specific materials, WMCI staff members hired a marketing firm to design professional materials aimed at capturing a reader's attention. This was especially important in that many focus group participants said that managed care was "boring" and "complicated." The program also worked with the marketing firm to develop a highly detailed plan for marketing the materials through a combination of posters; advertising; and extensive networking through nonprofit organizations, health care providers, and local and State agencies and community-based organizations to which women were already connected.

Results

Based on the research conducted in the initial phase of the project, the network developed a booklet titled *Managed Care and You: A Simple Guide to Choosing and Using a Managed Care Health Plan*. Other written educational materials included a series of short factsheets on specific managed care topics and a reminder card that lists important things to remember when selecting a plan and accessing services. As recommended by focus group participants (including those with the highest education levels), all education materials were easy to understand—not just in the way they are written but also in how they are designed. The project also conducted a limited number of educational workshops on managed care.

WMCI has not yet had an opportunity to conduct a formal evaluation of its program because the education campaign was just recently launched. However, the project has thus far achieved all its intended goals and objectives.

Potential for Replication

WMCI's approach to conducting research about the needs of the target audience has the potential to work well in other rural areas. Educational materials and vehicles must be developed in response to the unique educational needs and demographics of the target area. Similar efforts should be used by existing community networks, health care providers, and social service agencies as contact points for reaching targeted audiences.

After the Grant

The program is operating on no-cost extension grant funds, after which the Governor's Commission on Women will no longer have staff dedicated to the project. The commission continues to publicize and distribute materials, and it seeks funding to produce an educational video on managed care to be used as a supplement to the written materials.

Population Served

In southeastern Vermont, the health care delivery environment would be best described as fragmented and episodic. There is a high incidence of chronic diseases related to unhealthy behaviors and insufficient participation in prevention and health education activities. There are also high rates of child abuse and neglect, teen pregnancy, and substance abuse. The transient population throughout the area is growing, and these individuals typically lack the financial resources or experience in community involvement to access services. These problems are magnified by the fact that this rural region generally lacks centralized or easily accessible health and social services.

The Windsor Community Health Initiative (WCHI) was designed as a community outreach and health education program to improve the health status of people living in the Vermont towns of Windsor, West Windsor, Weathersfield, and Hartland. The project was also designed to serve as a starting point for creating a coordinated and collaborative health and human services infrastructure. It targeted school-age children and adolescents at Windsor Elementary and Windsor Junior/Senior High Schools, their families, and other members of the community.

Services Provided

The WCHI consortium was composed of 15 diverse local organizations representing all segments of the Windsor community as well as citizens and parents. Together, the consortium established several goals for the local community:

- Reduce fragmentation of care and the lack of centralized, easily accessible services.
- Improve the quality and duration of life, and reduce disabilities associated with chronic diseases.
- Reduce the incidence of infectious diseases through immunization and education.
- Reduce the incidence of violence and abuse through coordinated intervention.
- Reduce alcohol and other drug use through prevention, treatment, and education.
- Reduce the incidence of teen pregnancy.

VERMONT

WINDSOR COMMUNITY HEALTH INITIATIVE MT. ASCUTNEY HOSPITAL AND HEALTH CENTER

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To achieve these goals, the WCHI launched a broad range of health, social service, and education programs. For example, Mt. Ascutney Hospital and Health Center serves as the home to a new diabetes clinic as well as a free clinic for uninsured and underinsured individuals and families. The hospital also sponsored hepatitis B and tuberculosis clinics for Windsor area fire and police departments, school systems, local groups, and area residents. The program developed a new Tobacco Prevention and Control Coalition that emphasized education, prevention, and community awareness and provided health education classes on a wide variety of topics in local schools and throughout the community. The School Nurse Program was created to ensure that all school-age children were fully immunized. The Youth Advocate Program worked with students, school administrators, and teachers to reduce violence in the school system. Local parents were able to receive anger management training, and self-defense courses were offered for women. The Parent Connection Program matched mature, caring parents with struggling parents. A certified alcohol and drug abuse counselor who worked in Windsor Junior/Senior High School provided individual and group counseling, sobriety support groups, smoking cessation groups, social responsibility education, peer-to-peer student leadership training, referrals to outpatient and residential treatment, and a range of other services. The school also launched a "Baby, Think It Over" program to reduce teen pregnancy and has joined forces with other consortium members to create a communitywide abstinence program.

Innovative Solutions to Problems

One unique feature of the program is the Family Resource Center. Instead of reacting to family crises, the center focuses on early intervention and interagency case management to support and strengthen families before they reach the crisis stage. Another innovative effort is the "In Your Face Gorilla Theater" dance troupe. The troupe travels throughout the community to educate young people about substance abuse, alternatives to violence, and teen pregnancy.

Indeed, WCHI offered a broad array of innovative programs and services that benefited those living in and around Windsor. However, these exciting initiatives also sapped the energy of the consortium members, who found themselves participating in numerous planning, information-sharing, and evaluation meetings. Eventually, the consortium evolved into the Windsor Area Community Partnership, which kept track of the broad range of services and activities being conducted throughout the community; facilitated cross-agency communication; and conducted evaluations, which gave consortium members more time to conduct their activities and to cultivate new ideas.

As the program neared the completion of the grant cycle, the Vermont Prevention Institute Consult Team was asked to facilitate a review of WCHI. After analyzing the initiative's strengths and weaknesses, the team helped consortium members outline their sustainability strategy. Although difficult and time consuming, this process ultimately resulted in a unified vision for the long-term health and well-being of the community and widespread consensus as to where the program should go in the future.

Results

At the end of the 1997, 1998, and 1999 school years, 99.8 to 100 percent of students were in compliance with their immunization schedules compared with 24 percent in 1996. In 1997, there were 42.1 deaths per 100,000 people associated with diabetes, compared with 48.1 per 100,000 in 1991. Alcohol use in the past 30 days among 8th graders declined from 38 percent in 1995 to 27 percent in 1997. Marijuana use among 8th graders declined from nearly 36 percent in 1995 to 21 percent in 1997. Cigarette smoking in the past 30 days declined from 26 percent in 1995 to 17 percent in 1997. Although the community celebrates the progress that has been made, it is widely recognized that these are ongoing problems that will require a long-term strategy. The bottom line, however, is that WCHI made substantial progress in achieving its goals, and patients of the free clinic gave the staff high marks for courtesy; their listening ability; caring attitudes; careful and intelligible explanations; and help in finding other services, such as prescriptions and insurance.

The job of connecting service providers to one another and making services more easily accessible remains undone. Area providers still wish that there was a single number to call to initiate services for a patient, and some still feel "out of the loop." However, one of WCHI's spinoff grants is working to secure funding to renovate a downtown building where all social services can be housed under one roof.

Potential for Replication

Rural communities across the Nation are struggling to overcome distance and access barriers to services in an environment of dwindling resources. However, as long as consortium members are willing to change institutional modes of operation when necessary; work in collaborative teams; and learn from visionary, motivated, and patient leaders, success can be achieved. The concepts of coalition-building and community partnership may be daunting at first, but they were successfully accomplished in Windsor. The same thing can happen elsewhere.

The most common challenges other communities may face will most likely include territorial issues among agencies. These problems usually result from miscommunication and lack of information. Other communities must have the courage and dedication to confront these attitudes and beliefs because the benefits are well worth the effort. Finding professionals with the right talent, attitude, and expertise also may present a challenge.

After the Grant

The activities and services created as a result of the Rural Health Outreach Grant continue to be offered. In fact, new funding sources have made it possible to enhance many of the available services and to create new services. The Windsor Area Community Partnership also will continue to provide overall leadership, coordination, and evaluation.

WISCONSIN

ON DIFFERENT GROUND

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Population Served

Northern Wisconsin's Forest, Oneida, and Vilas Counties have one of the highest concentrations of lakes and rivers in the world. The region's beauty, however, is somewhat overshadowed by the fact that many area residents, especially the elderly and disabled, are geographically isolated from health care services.

Geography is not the only barrier that prevents the elderly and disabled from receiving the care they need. In addition, some elderly residents are fiercely independent and suspicious of the government (or of programs funded by the government). Others simply are not able to seek help, are reluctant to ask for help, or lack the resources to pay for services. Subzero temperatures and an average of 57 inches of snowfall each year also make it difficult to access services.

When it comes to mental health and substance abuse services, the elderly and disabled face additional barriers to care. Although the need for mental health and substance abuse services is great, programs are often designed with younger clients in mind, and services are not always individualized in a way that is sensitive to the unique needs of elderly and disabled clients.

Services Provided

In 1996 three area service organizations joined forces to launch the "On Different Ground" program. The grantee organization, the Human Services Center, administered the project and provided resources and referrals. Koller Behavioral Health, a department of the Howard Young Medical Center, provided mental health and substance abuse training, in-home counseling and treatment, office space, clerical assistance, and clinical supervision for the project. The Northern Area Agency on Aging served as a central contact source for three county commissions on aging and three tribal agencies.

The program served adults older than 60 years, tribal adults older than 55, and disabled adults older than 18 who were unable to seek traditional services and required in-home substance abuse and mental health counseling, support, or treatment. The project was designed to link mental health, substance abuse, primary care, and social support service providers so that elderly and disabled residents in the tricounty area could receive care in their own homes.

Innovative Solutions to Problems

The most innovative feature of the On Different Ground program was its emphasis on serving clients in their homes rather than waiting for clients to come to the program. This feature is particularly important because the program targeted a significantly underserved population experiencing numerous, complex barriers to care. Another project innovation was the coordination of existing health care, aging, and social service programs to create a comprehensive service network specifically designed to meet the needs of local elderly residents.

The project delivered services from a "wraparound" approach so that specific services were tailored to each client's individual needs. Whenever possible, clients were directly involved in determining what services they received, based on their particular needs and strengths; the program placed strong emphasis on providing care responsive to each client's cultural expectations.

One of the biggest challenges the program faced was addressing the widespread need for transportation to services that could not be provided in clients' homes. The project had to establish ground rules for determining who received transportation and who did not, and at times, staff members who lived close to clients transported them to and from services and were reimbursed for mileage when they used their own vehicles.

The program also recognized an enormous demand for "soft" mental health services. For example, some clients were lonely and isolated and were seeking companionship. Project staff members made a concerted effort to be as supportive as possible and to use the wraparound delivery approach to meet these client needs.

Results

At the outset, On Different Ground was designed to achieve five key goals:

- Create a comprehensive mental health/substance abuse service delivery system for elderly and disabled individuals and their families.
- Increase awareness of mental health and substance abuse problems among elderly and disabled individuals.
- Increase the knowledge and skills of home health personnel, social workers, rehabilitation staff, benefit specialists, and supportive care workers and improve their ability to serve elderly and disabled clients with mental health and substance abuse problems.
- Increase the knowledge and skills of alcohol, drug abuse, and mental health counselors as they relate to serving elderly and disabled clients.
- Increase the number of elderly and disabled clients receiving mental health and substance abuse counseling and support services through existing community services.

The program achieved all these goals. Among the more than 200 clients served, 82 percent reported a better understanding of substance abuse, and 97 percent indicated that they would recommend the program to their family and friends. A full 100 percent reported that they felt better as a result of receiving care, and 100 percent reported being satisfied with the services they received. After receiving services, 73 percent reported that their emotional health was "good" or "excellent," and 51 percent reported that their physical health was "good" or "excellent."

Providers and staff members received training in nonviolent crisis intervention; the process of working with older adults; the needs of elderly persons with substance abuse problems, Alzheimer's, and dementia; grief counseling; cultural awareness; and home safety. In addition, an evaluation of Medicaid expenditure information on a small percentage of clients found that the program provided health care access to a population that may not have had any other opportunity to receive care.

Potential for Replication

On Different Ground was created with its replicability in mind. The way that the program is organized and operates maximizes existing services, reduces duplication, and meets the needs of a population that may not be effectively served by traditional mental health and substance abuse treatment approaches.

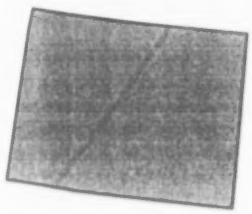
Projects of this nature require creative approaches to secure funding, locate dedicated professional and paraprofessional staff, and undertake staff training. Program planners should also consider the degree to which transportation is a barrier for clients living in the targeted community.

Ongoing communication, education, and training among service providers supply the foundation for successful integrated service delivery, and having a stable, dedicated staff allows the project to grow and to meet the needs of a larger number of clients. Evaluation tools and databases should be established early in the project's development, and the ongoing review of data and activities enables staff members to identify program strengths as well as opportunities for improvement.

After the Grant

Future funding opportunities are being explored; meanwhile, integrated services, in some capacity, will continue to be provided to elderly and disabled persons throughout the region.

WYOMING



SOUTHERN CAMPBELL COUNTY EMERGENCY SERVICES PROJECT

GILLETTE, WYOMING

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Population Served

Southern Campbell County, Wyoming, is a rural area that relies predominantly on the gas, oil, coal, and rail industries to drive the local economy; it covers approximately 5,000 square miles. The town of Wright has a population of 1,400 and is located 38 miles south of Gillette, which has a population of approximately 20,000.

The goal of the project was to expand and enhance emergency medical services (EMS) available to the people living in southern Campbell County and to increase the number of individuals trained to provide high-quality, prehospital emergency response. Before the Rural Health Outreach Grant was received, volunteer EMS personnel in Wright were unable to provide 24-hour service. Although 24-hour service was supported by Campbell County Memorial Hospital, the hospital was nearly 40 miles away in Gillette.

Services Provided

The project consortium compromised Campbell County Memorial Hospital, the town of Wright, the Campbell County Volunteer Fire Department (Wright Station), and Southern Campbell County Emergency Services (SCCES). The hospital provided administrative and fiscal support for the project and served as the "hub" for advanced EMS clinical training and instruction. The EMS responders worked under the direction of one of the hospital's emergency department physicians.

The town of Wright provided a housing allowance of $500 per month to a Wright-based paramedic. A series of meetings with the Wright Town Council provided a forum for determining ambulance staffing, sharing financial concerns, providing status reports, and developing a contract between the town of Wright and Campbell County Memorial Hospital for ambulance leases and services.

The Campbell County Fire Department (Wright Station) provided EMS responder cross-training under the direction of a full-time assistant chief, who also provided intermediate-level EMS training to two career individuals. Training opportunities were often offered in Wright, making it easier for trainees to attend.

Project 24—Southern Campbell County Emergency Services Project

At the time the project was developed, SCCES was a member of the consortium. However, once there was a hospital-employed paramedic living and working in Wright and providing emergency responses and training, SCCES dissolved. Sadly, not all the previous EMS providers joined the new project, thereby creating some tension and hardship early in the project. Existing ambulances were then leased by the hospital from the town of Wright.

Innovative Solutions to Problems

The project experienced difficulty recruiting and retaining a Wright-based paramedic. In addition, the original group of volunteer providers was small, which made it impossible to provide 24-hour EMS. These challenges were complicated by the fact that Wright is an isolated community, making recruitment of trainees from other towns to provide emergency services in Wright difficult. To address this challenge, the project focused its efforts on cross-training local firefighters who already possessed a strong commitment to serving the community. Eventually, when the third paramedic was hired and the project was under stable direction and leadership, others in the community began to express an interest in receiving training as volunteer emergency personnel. In addition, the Wright Town Council made a concerted effort to acknowledge the successes of the EMS program and to recognize volunteer EMS staff.

Results

In the first year of the project, Wright EMS personnel responded to 67 emergency incidents. In year 2, they responded to 117 incidents, and the majority of individuals served were between ages 20 and 64.

One goal for the first year of the project was to upgrade the community's paging and communications systems. The project set up a radio-based system that allowed the county dispatch center to notify responders when there was an emergency. The system was also expanded to include two-way communications between ambulances in Wright and the emergency department physician in Gillette. However, the project was not able to purchase new radios and pagers, so recurring equipment maintenance and repairs continued to be a problem.

In addition, cardiac monitoring equipment was purchased and was placed on the Wright ambulance in the project's first year. It provided the Wright paramedic with the same technological capabilities available to the Gillette paramedics. Before the grant, no EMS provider in Wright had been certified to use a cardiac monitor.

Today, Wright EMS personnel are available to provide emergency response around the clock. When a large number of Wright personnel are absent or on vacation, Gillette EMS personnel provide backup support. A total of 7 advanced life support providers are currently on staff, and 15 staff members are currently listed on the Wright EMS roster. Of these, two are the full-time paramedics, one is the fire department assistant chief, and eight staff members serve both the fire department and the EMS. Other than the two full-time personnel, all other staff members have full-time job requirements outside the fire department and the EMS. In addition, the Wright-based paramedic continues to provide bimonthly continuing education. Additions to the video library and computer access also enhance the training process.

Potential for Replication

To establish or enhance emergency medical services in rural areas, a great deal of time must be dedicated to preparation, planning, and human resources. Often, people want to help, but for various reasons, they are not always able to complete the necessary training to receive certification. In some cases, staff members may be unable to perform during emergency situations because the people needing care are their friends and neighbors.

Perhaps the biggest challenge in creating a rural emergency medical service is recruiting a senior paramedic who can provide the stability and leadership necessary to make such a project successful. It is also difficult to maintain staff skills when emergency calls are few and far between. However, when such a program is adequately staffed, it may be possible to arrange for EMS personnel to work periodically in larger, more active EMS stations so that they can regularly use their skills.

After the Grant

Campbell County Memorial Hospital is absorbing the cost of the Wright EMS program, and no fundraising activities are planned. Additional volunteers are expected to join and receive training through classes offered by the State.

Population Served

This project targeted physically disabled persons, elderly individuals, and other persons needing medical rehabilitation services who live in north-central Wyoming (Sheridan and Johnson Counties) and southern Montana (Big Horn County). Specifically, the project focused its efforts on addressing the region's five leading causes of death—heart disease, stroke, neuromuscular disease, cancer, and unintentional injuries.

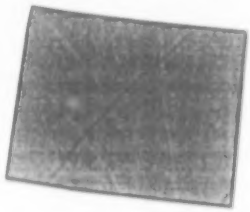
Before the creation of this project, comprehensive medical rehabilitation services were nearly impossible to access. There were significant service gaps, and residents needing comprehensive medical rehabilitation either traveled out of the region to receive care or did without services altogether.

Services Provided

The project was designed to achieve three overarching goals: to develop a comprehensive, coordinated range of medical rehabilitation services in the region; to increase access to medical rehabilitation services for physically disabled and elderly individuals; and to prepare residents to receive future rehabilitation services in a managed care environment.

To achieve these goals, four organizations located in the Sheridan community joined forces. The Memorial Hospital of Sheridan County provided space and equipment for inpatient and outpatient rehabilitation services; made referrals to physical, occupation, and speech therapy; and offered a health enhancement program for individuals receiving cardiac and pulmonary services. The Sheridan County YMCA provided space and equipment for aquatic and physical therapy, rehabilitation and exercise programs, and a health enhancement program for cardiac patients and persons suffering from other serious diseases. The Sheridan Community College leased space for occupational therapy and for cardiac/pulmonary rehabilitation, provided space and equipment for a community wellness program, and developed a curriculum and training programs for the wellness program. Finally, the Sheridan County Senior Center provided transportation; elder care services (at a capitated rate); and space for a senior fitness program, a health education program, and screenings. The Wyoming Rehabilitation Foundation operated under the direction of a board

WYOMING



WYOMING REHABILITATION FOUNDATION

SHERIDAN, WYOMING

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of directors, which comprised representatives of the consortium organizations, the foundation's executive director, and two medical directors.

The program recruited a diverse range of rehabilitation professionals, including occupational therapists, a respiratory therapist, a prevention coordinator, a social worker, an exercise coordinator, physical therapists, a speech therapist, and cardiac rehabilitation nurses. Depending on each patient's individual needs, services were provided at the hospital, on an outpatient basis, or in the patient's home. Primary rehabilitation services included physical, occupational, and speech therapy. However, the grant also supported a range of health enhancement programs, social services, case management, injury and healthy screenings, support groups, a lecture series, community health fairs, and transportation. During the first year of the grant, services were available only in Sheridan County. In the second year, the service area was expanded to include Johnson County. The program also served residents of Big Horn County in Montana, but mainly only during the project's third year.

Case management services were based on an individualized service plan. The program also established general clinical protocols, protocols for specific medical problems, and quality indicators. Clinical staff members attended ongoing specialized training to ensure that they remained knowledgeable of state-of-the-art modalities and interventions. Most important, services were provided to residents of the target area—regardless of their ability to pay.

Innovative Solutions to Problems

One of the key challenges faced by the program was unexpected territoriality from other community providers. As a result, consortium members spent a great deal of time educating local providers about the initiative's goal to fill rehabilitation service gaps—not to duplicate existing services. The program also discovered that the cost of providing ancillary services (e.g., mental health, nutrition, and social work) was higher than originally expected. To address this problem, the program provided comprehensive and intensive case management services so that patients could access alternative resources to finance these services. This strategy proved to be more cost-effective for the program and easier for clients.

Meeting the needs of the uninsured and underinsured proved to be a difficult challenge. There were not enough funds to cover the cost of medical rehabilitation services for those who could not pay or had inadequate coverage. As a result, the program made some significant changes in its fiscal management so that it would be better equipped to cover such costs.

Throughout the project, the foundation placed strong emphasis on quality of care and program efficiency. For example, the foundation launched an Outcome Measurement System, which involved using medical rehabilitation computer software, peer reviews, internal evaluations, external audits, and consultation with professionals outside the foundation. The system tracked and measured program efficiency, treatment outcomes, services costs, and client and provider satisfaction.

Results

Today, the Wyoming Rehabilitation Foundation offers a comprehensive range of coordinated medical rehabilitation services for victims of heart disease, stroke, neuromuscular disease, cancer, and unintentional injuries in all three counties in the service area. The program created a community wellness program, a healthy back program, cardiac/pulmonary screenings, senior fitness programs, health fairs, a lecture series on medical issues, employer training on preventing work-related injuries, "Elderly Falling" seminars for professionals who work with seniors, and a resource directory for rehabilitation services in all three counties. The program also successfully established collaborative relationships with ancillary providers so that patients had access to mental health, nutrition, and social work services.

During the 3-year grant period, the program reached 50 percent of the target population. This was accomplished through significant media coverage of the foundation and through the development and broad dissemination of information about the program and its services. It is estimated that the program served more than 3,500 new patients, most of whom were female and between ages 20 and 64.

The most important lesson learned by the foundation was that strong, collaborative relationships among community organizations needed to be established before services and programs were implemented. Forming positive partnerships was critical in understanding the service needs of the targeted population and the political environment in which services were delivered. This is especially important in rural areas, where territoriality can easily become a barrier to service delivery and program development.

Potential for Replication

Although "small-town America" typically lacks many of the resources that are more readily available in highly populated areas, many rural residents need medical rehabilitation services to enhance their health and well-being. There is little doubt that projects similar to the Wyoming Rehabilitation Foundation can be

developed and implemented in other rural areas. In fact, many rural communities will need to do so because managed care programs may not be able to provide a comprehensive continuum of care for those who need medical rehabilitation services.

When community agencies work together, service duplication can be reduced or eliminated. Agencies can also maximize their resources by sharing facilities and equipment. Networking within the community and creating strong community affiliations can result in positive outcomes for the residents, families, organizations involved, and community at large.

However, it is important that rural communities understand the unique characteristics of each community, educate residents about the project and its services and goals, and generate broad-based community support, build and maintain a strong consortium, dedicate sufficient time to program planning, maximize limited resources, and provide effective financial management.

After the Grant

The services made available during the grant period will continue to be offered after project funding ends and as long as the need exists. Payment for services will be supported by patient fees and a variety of local grants.

CONTINUING EDUCATION FOR HEALTH PROFESSIONALS	*PROJECT NUMBER*
Emergency medical services personnel	
Emergency medical technicians	15
Firefighters	15, 24
Paramedics	24
Emergency room personnel	
Nurses	12, 25
Physicians	12, 13, 17, 18, 19, 20, 24
Social workers	23
Subject	
Survival	16

HEALTH PROMOTION/EDUCATION	*PROJECT NUMBER*
Health promotion/disease prevention (general)	13, 15, 16, 19
Health promotion/disease prevention (specific)	
Anger management	19, 22
Child abuse	19, 22
CPR	12
Dementia	23
Depression	15, 20
Diabetes	15, 19, 20, 22
Drug abuse	12, 22, 23
First aid	12, 15, 18
Mental health	12, 13, 18, 20, 23, 25
Nutrition	12, 13, 14, 15, 18, 20, 25
Self-esteem	18
Sexuality	18
Smoking cessation	15, 18, 22
Substance abuse	18, 22, 23
Tobacco prevention	15, 22
Peer counseling	18

POPULATION GROUP	*PROJECT NUMBER*
Adolescents	18, 22
Children	2, 5, 6, 7, 8, 9, 10, 11, 12, 19, 21, 22

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POPULATION GROUP (CONTINUED)	*PROJECT NUMBER*
Disabled	23, 25
Elderly	2, 14, 15, 16, 23, 25
Infants	1, 7, 11, 12, 19, 21
Minorities	
African-American	5, 16
Amish	15
Hispanic	8, 9, 12
Native American	12, 14, 17
Pregnant women	12
Women	1, 2, 5, 8, 11, 12, 15, 19, 20, 21, 22

SERVICES	*PROJECT NUMBER*
Advocacy	1, 5, 6, 21
Case management	1, 5, 18, 19, 22, 25
Counseling services	11
Dental care	1, 2, 20
Emergency medical services	24
Health fairs	2, 5, 9, 25
Immunizations	5, 7, 10, 18, 19
Library	24
Media coverage	19
Medicaid	Program Overview, 6, 7, 8, 12, 14, 18, 19, 20, 23
Medicare	12, 14
Mental health services	1, 5, 11, 12, 18, 20, 23

SERVICES (CONTINUED)	*PROJECT NUMBER*
Preventive health care	20
Primary care	1, 2, 5, 11, 13, 15, 18, 19, 23
Public health	5, 6, 7, 9, 12, 13, 16
Referrals	5, 6, 8, 9, 15, 18, 19, 20, 22, 23, 25
Screenings (general)	2, 5, 7, 11, 12, 14, 15, 18, 25
Screenings (specific)	
Blood pressure	15
Blood sugar	2
Cholesterol	2, 15
Dementia	23
Dental	1, 2, 5, 11, 20
Diabetes	2, 15, 19, 20, 22
Mental health	1, 5, 11, 12, 13, 18, 20, 23, 25
Pregnancy	2, 5, 12, 18, 22
Prostate screenings	2
Vision	1, 8, 18, 22, 23
Sports physical	2
Support group	
Cancer	2, 11, 15, 16, 19, 25
Telemedicine	12, 17
Tuberculosis testing/management	5

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PROJECT TITLE, LOCATION	*PROJECT NUMBER*
Ashland Public School Board, Ashland, Montana	12
Clinton County Community Health Outreach Project, Lock Haven, Pennsylvania	15
Concordia Rural Services Project, Ferriday, Louisiana	5
Dakota Health Network Project, Aberdeen, South Dakota	17
DOCS Rural Outreach Program, Miami, Oklahoma	14
Harlan County Homeplace, Evarts, Kentucky	4
Health Outreach Project, Houghton, Michigan	7
Healthy Connections, Truro, Massachusetts	6
Loudon School Health Consortium, Lenoir City, Tennessee	18
Lower Rio Grande Promotora Collaboration Project, Monroe, Michigan	8
Marvell Medical Clinic, Helena, Arkansas	2
On Different Ground, Rhinelander, Wisconsin	23
Ozark Foothills Child Health Care Program, Poplar Bluff, Missouri	10
Project HOPE, Potosi, Missouri	11
Project SCOUT, Albany, Texas	19
Rural Health Services Outreach Grant Program, Hendersonville, North Carolina	13
Saludando Salud, Mankato, Minnesota	9
Southern Campbell County Emergency Services Project, Gillette, Wyoming	24
Sunshine Community Health Center, Talkeetna, Alaska	1

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PROJECT TITLE, LOCATION	*PROJECT NUMBER*
The ASSURE Project, Washington, Iowa	3
Vermont Coalition of Clinics for the Uninsured, Middlebury, Vermont	20
Windsor Community Health Initiative, Windsor, Vermont	22
Women and Managed Care Initiative, Montpelier, Vermont	21
Wyoming Rehabilitation Foundation, Sheridan, Wyoming	25
Yemassee Outreach Network, Fairfax, South Carolina	16